CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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DEFINITION OF PERSONAL ATTENDANT SERVICES

Personal attendant services are defined as long-term maintenance or support services that are necessary to enable an individual to remain at or return home and remain in the community rather than enter a nursing facility or hospital. Personal attendant services provide eligible individuals with personal attendants who perform basic health-related services, such as helping with ambulation exercises, assisting with normally self-administered medications, and providing household services essential to health in the home and in the community. Specifically, personal attendant services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for individuals to remain in their homes and communities. Personal attendant services cannot be offered to individuals who are residents of nursing facilities, adult care residences, or adult foster homes licensed or certified by the Department of Social Services (DSS).

COVERED SERVICES

The Department of Medical Assistance Services (DMAS) will only reimburse services defined as personal attendant services. Personal attendant services to be provided by personal attendants in the home are limited to the following:

- Assisting with care of the teeth and mouth;
- Assisting with grooming (this would include care of the hair, shaving, and ordinary care of the nails);
- Assisting with bathing of the individual in bed, in the tub, in the shower, or a sponge bath. Routine maintenance and care of external condom catheters is considered part of the bathing process. This care applies only to external and not in-dwelling catheters (e.g., Foley catheters);
- Providing routine skin care, such as applying lotion to dry skin, not to include topical medications or any type of product with an “active ingredient”;
- Assisting the individual with dressing and undressing;
- Assisting the individual with turning and changing position, transferring, and ambulating;
- Assisting the individual with toileting (including moving on and off of the bedpan, commode, or toilet);
- Assisting the individual with eating or feeding;

- Assisting the individual with self-administered medications and assuring that the individual receives medications at prescribed times not to include in any way determining the dosage of medication;

- Assisting the individual while the individual works. The attendant may assist only with activities of daily living associated with the individual and may not assist with the completion of the individual's work-related tasks;

- Administration of bowel and bladder programs by the attendant under special training and supervision. Administration of bowel and bladder programs must be ordered annually by the physician. This order from the physician must specify that the recipient requires administration of bowel or bladder programs and the frequency to be administered. The personal attendant may be authorized to administer physician-ordered bowel and bladder programs to individuals who do not have other support available. This authorization could only be given for these reasons:

    - The provider or contracted RN, if the provider is not a RN, has documented that the attendant has received special training in bowel and bladder program management;

    - The attendant has knowledge of the circumstances that require immediate reporting to the individual's physician; and

    - The provider or the RN contracted by the provider has observed the attendant performing this function.

    The Pre-Admission Screening Team may not include this service on the Plan of Care prior to contacting the services facilitator to assure that the attendant hired by the individual has received adequate training. See Appendix B of this manual for a full description of the pre-admission screening criteria and process.

    The Pre-admission Screening Team may not include this service on the Plan of Care if certain conditions exist that would contraindicate having the attendant perform a bowel program (e.g., patients prone to dysreflexia such as high level quadriplegics, head and spinal-cord-injured patients, and some stroke patients). The bowel program may include, if necessary, a laxative, enemas, or suppositories to stimulate defecation.

    However, the laxative cannot be "administered" by the personal attendant, even through part of the bowel program (suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel program). Replacement of a colostomy bag as part of the bathing process is included. Digital stimulation and removal of feces within the rectal vault may be a necessary part of the bowel maintenance or training program. However, removal of impacted material is not permitted. (None of the procedures

included here may be administered except as part of a physician-ordered bowel program.)

The bladder program may not include any invasive procedures such as catheterization, instillation, or irrigation, but can include bladder-training activities. Bladder retraining is limited to time management of urination without any invasive procedures or voiding stimulation. The provider or the RN contracted by the services facilitator must be available to the attendant and be able to respond to any complications immediately;

- Administration of range of motion ("ROM") exercises by the personal attendant. ROM exercises must be ordered annually by the physician. This order from the physician must specify that the recipient requires ROM exercises and the frequency to be administered. ROM exercises ordered by the physician may be performed by the attendant when the attendant has been instructed by the RN in the administration of range of motion exercises, and the attendant's correct performance of these exercises has been witnessed and documented by the RN. This does not include strengthening exercises or exercises aimed at retraining muscle groups, but includes only those exercises used to maintain current range of movement without encountering resistance;

- Routine wound care by the attendant that does not include sterile technique. The attendant can perform routine wound care that does not include sterile treatment or sterile dressings. This would include care of a routine decubitus ulcer, defined as a decubitus ulcer which is superficial or does not exceed stage 1 (sore penetrates to the underlying subcutaneous fat layer, shows redness, edema, and induration at times, with epidermal blistering or desquamation). Normal wound care would include flushing with normal saline solution, washing the area, drying the area, and applying dry dressings as instructed by the RN. This does not include the application of any creams, ointments, sprays, powders, or occlusive dressings;

- Checking the temperature, pulse, respiration, and blood pressure and recording and reporting as required; and

- Home Maintenance Activities. These activities, which are related to the maintenance of the home or preparation of meals, should only be included on the Plan of Care for individuals who do not have someone available either living in the home or routinely coming in to provide assistance. Individuals living in the home with the individual who would be expected to perform housekeeping and cooking activities for themselves should provide the individual's home maintenance activities while completing their own. These activities are:

    - Preparing and serving meals, not to include menu planning for special diets;

- Washing dishes and cleaning the kitchen;
- Making the bed and changing linens;
- Cleaning the individual's bedroom, bathroom, and rooms used primarily by the personal care individual;
- Listing for purchase supplies needed by the individual;
- Shopping for necessary supplies for the individual if no one else is available to perform the service; and
- Washing the individual's laundry if no other family member is available or able.

Attending to Needs of Recipients Who Work or Attend School, or Both

Recipients who wish to enter the C-DPAS Waiver may continue to work or attend school, or both, while they receive services under this waiver. The attendant who assists the recipient may accompany that person to work/school and may assist the person with waiver services while the individual is at work/school. DMAS will pay for any waiver services that are given by the aide to the enrolled recipient while the recipient is at work/school. DMAS will also pay for any services that the attendant gives to the enrolled recipient to assist him or her in getting ready for work/school or when he or she returns home.

DMAS will not pay for the attendant to assist the enrolled recipient with any functions related to the recipient completing his or her job/school functions or for supervision time during work or school.

DMAS will review the recipient's needs and the complexity of the disability when determining the services that will be provided to the recipient in the workplace/school.

DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) or the Rehabilitation Act of 1973. For example, if the recipient's only need is for assistance during lunch, DMAS would not pay for the attendant for any time extending beyond lunch. For a recipient whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the recipient is physically unable to speak or make himself understood even with a communication device, the attendant's services may be necessary all day. DMAS will reimburse for the attendant's services unless the attendant is required to assist the recipient all day as a part of the ADA or the Rehabilitation Act of 1973.

The services facilitator must develop an individualized plan of care which addresses the recipient's needs at home, work, and/or in the community.

Example: Mr. Jones is enrolled in the C-DPAS Waiver. He works outside the home for five (5) hours each day. His attendant assists him with getting ready for work in the

morning and accompanies Mr. Jones to work. The attendant may assist Mr. Jones with any care such as bathroom needs during the time that Mr. Jones is at work. Mr. Jones actually requires his attendant's assistance for a combined total of one (1) hour per day during the five-hour period that he is working, but the attendant is providing supervision for the total five-hour period. The recipient's plan of care must include the full five hours for the provider to be reimbursed by DMAS. The provider must have authorization for supervision for this recipient.

Transportation

The personal attendant may be allowed to transport the individual in the individual's vehicle or accompany the individual to assist the individual with his or her Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) as stated and documented in the individual's plan of care. The personal attendant may drive the individual only in the individual's or their vehicle if all of the following criteria are met:

- The total time required by the personal attendant for the day, including the time required to drive the individual, does not exceed the individual's weekly authorized hours. If the total time required exceeds the daily hours, the additional time may be deducted from another day as long as this does not jeopardize the individual's health and safety;
- The vehicle is registered in the Commonwealth of Virginia;
- The vehicle owner has current automotive insurance containing collision, comprehensive, and liability coverage with a minimum of 100-300-50. The insurance must insure the individual and cover the personal attendant as a driver of the individual's vehicle;
- The personal attendant has a valid Virginia driver's license; and
- It is necessary to assist the individual with his or her ADLs or IADLs as documented in the individual's Plan of Care.

Services Excluded from Coverage/Reimbursement under Personal Attendant Care

DMAS will not reimburse personal attendants for any services that are not listed above. These include, but are not limited to, the following activities:

Skilled Services

Services requiring professional skills or invasive therapies, such as tube feedings, Foley catheter irrigations, suctioning, sterile dressings, or any other procedures requiring sterile technique, cannot be performed by personal attendants. Routine maintenance and care of external condom catheters does

not constitute a skilled service and can be performed by the personal attendant as part of the bathing process.

Provision of Services for Other Members of the Individual's Household Who Are Not Medicaid Personal Attendant Individuals

DMAS will reimburse the personal attendant only for services rendered to the individual. DMAS will not reimburse the personal attendant for services rendered to or for the convenience of other members of the individual's household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing dishes, family laundering, etc.) DMAS also will not reimburse for the provision of unauthorized services.

RELATION TO OTHER MEDICAID-FUNDED HOME CARE SERVICES

Virginia currently offers one other home-based service through the Virginia *State Plan for Medical Assistance*: home health care.

Home Health

The major differences between home health and personal attendant services are the increased involvement of professional medical personnel in home health services and the emphasis in home health on short-term, intermittent, restorative care rather than long-term maintenance functions. A home health aide shall be assigned when the responsible physician has specified the need for such a service in the individual's Plan of Care. This Plan of Treatment must be re-evaluated and signed by the responsible physician not less than once every 62 days. The RN shall make a supervisory visit to the individual's residence at least every two weeks to assess relationships and determine whether goals are being met.

Personal attendant services are defined as long-term maintenance or supportive services which are necessary to enable the individual to remain at home rather than enter a nursing facility or hospital. Although attendants may provide care to individuals requiring skilled care, they cannot perform any services not outlined in this chapter.

Services requiring professional skills (such as tube feedings, tracheotomies, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique) cannot be performed by personal attendants. It is permissible for a nurse to give skilled services at the same time that the personal attendant is in attendance. Medicaid cannot be billed for a home health aide and a personal attendant providing identical services to the same individual at the same time. Identical service is defined as the services listed in the section titled "Covered Services" in this chapter.

Home and Community-Based Long-Term Care Services

DMAS provides reimbursement for services (personal attendant care) designed to offer individuals an alternative to institutionalization. Individuals may be authorized to receive this service based on the documented need of the service to avoid nursing facility place-

ment. The Nursing Home Pre-Admission Screening Team (NHPAST) must give prior authorization for any Medicaid-reimbursed home and community-based care, subject to DMAS approval prior to reimbursement for any claims. Individuals cannot receive services from multiple home and community-based care waivers. For example, individuals cannot receive personal attendant services under the Consumer Directed-Personal Attendant Services Waiver and personal care aide services under the Elderly and Disabled Waiver simultaneously. The NHPAST will assist the individual with identifying the most appropriate service to meet the individual's long-term care needs.

HOSPICE SERVICES

Hospice is an autonomous, centrally administered, medically directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his or her family. It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during bereavement. The goal is to maintain the recipient at home for as long as possible while providing the best care available to the patient, thereby avoiding institutionalization.

To be covered, the recipient must elect hospice services, and his or her terminal illness (usually a prognosis of six months or less) must be certified by the recipient's attending physician and the hospice medical director. A hospice must routinely provide a core set of services including nursing care, physician services, social work, and counseling.

SIMULTANEOUS PROVISION OF C-DPAS WAIVER SERVICES AND HOSPICE SERVICES

The following information is applicable regardless of whether the hospice receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Recipients of C-DPAS Waiver services may be eligible to receive hospice services.

The hospice benefit provides comprehensive services to persons with a terminal illness. The hospice provider must offer homemaker/home health aide services as a part of the hospice benefit. Based upon the Medicare policy establishing the hospice reimbursement rates, it has been determined that the daily reimbursement rate covers the cost of providing a minimum of three hours per day of homemaker/home health aide services. The hospice provider must cover a minimum of 21 hours per week of homemaker/home health aide services for any recipient who requires those services. If the recipient chooses to receive hospice and CD services, the hospice provider must have supportive documentation of at least 21 hours per week of homemaker/home health aide hospice services and that the recipient needs consumer-directed attendant care-type services which exceed this amount.

CDPAS Waiver services provide a cost-effective alternative to nursing facility. This means that the cost to Medicaid for the recipient to receive care in the community must be equal to or less than the cost to Medicaid for that same recipient to receive care in a nursing facility. If a recipient is receiving hospice services, the maximum amount of CD personal

attendant services that is cost-effective is 5.5 hours per day (a maximum of 38.5 hours per week). This amount is based upon a comparison of the cost to Medicaid for a recipient in the community receiving both services and the cost to Medicaid for that recipient in a nursing facility involving hospice services.

Once a recipient elects the hospice benefit, the hospice becomes responsible for establishing an interdisciplinary plan of care designed to meet the individual needs of the recipient. If at the time of the hospice assessment, the recipient's needs indicate that more than 21 hours per week are needed and that these hours cannot be met by hospice staff, volunteers, the family support system, or other community resources, the recipient should be referred to a Nursing Home Pre-admission Screening Team (Screening Team). The Screening Team will evaluate whether the recipient meets the criteria for the C-DPAS Waiver. If a recipient is receiving consumer-directed personal attendant care services at the time that he or she elects the hospice benefit, and the criteria for receiving combined services are met, the hospice provider must send a copy of the interdisciplinary team plan of care with the hospice enrollment forms to avoid the automatic termination of the prior C-DPAS Waiver service authorization.

When personal consumer-directed personal attendant care services are requested in addition to the services being provided under the hospice benefit, the Screening Teams must:

- Determine the recipient's total needs for home care including an estimate of the daily number of hours required and document this on the Uniform Assessment Instrument (UAI) in the summary section;
- Indicate the name of the hospice involved on page 12 of the UAI and on the DMAS-97; and
- Authorize Consumer-Directed Personal Attendant Services, as long as the recipient will be safe in the home setting with the total amount of care available through the waiver, hospice care, and informal supports.

When submitting the enrollment package to WVMI for preauthorization, the service facilitator must include a copy of the hospice interdisciplinary team plan of care so that WVMI can allow reimbursement for simultaneous services. The hospice must coordinate with the service facilitation provider to establish and agree upon a plan of care that reflects the hospice care philosophy and is based on an assessment of the recipient's needs and unique living situation. The recipient and service facilitation provider must be involved in any and all decisions that affect the recipient's care.

If a hospice provider contracts with a personal care provider for the 21 hours of aide service under hospice, the aide must complete a DMAS-90 (Aide Records) only for the time billed to personal care.

The election of the hospice benefit is the recipient's choice rather than the hospice's choice. The hospice benefit is not designed to meet the needs of every terminally ill recipient. The

recipient and family must be fully informed of the services available and any limitation on those services prior to electing the benefit. Some recipients' needs may be more effectively met by utilizing other state and local programs and services. Once a recipient has been accepted for care, the hospice may not discharge the recipient at its discretion, even if the recipient's care becomes costly or inconvenient. The recipient must sign a revocation of hospice benefits in order for him or her to be discharged from hospice services.

For specific questions about the provision of C-DPAS Waiver services and hospice services, contact either WVMI at (804) 648-3159 in Richmond (or 1-800-299-9864 all other areas) or the DMAS Facility and Home-Based Services Unit at (804) 225-4222.

ASSESSMENT AND AUTHORIZATION PROCEDURES FOR PERSONAL ATTENDANT SERVICES

Services will be offered as an alternative to a nursing facility only to individuals who have been certified as eligible by the NHPAST, subject to the approval of DMAS. The team will have explored the medical, social, and nursing needs of the individual, analyzed specific services the individual needs, and evaluated whether a service or combination of existing services is available to meet these needs. The NHPAST will have explored alternative settings or services with the individual to provide the required care before making the referral for personal attendant services. Appendix B contains a copy of the DMAS criteria for nursing facility care. For detailed information regarding nursing home criteria, see Appendix B.

Federal regulations, governing Medicaid coverage of home- and community-based services under an approved waiver, specify that services provided under waiver authority must be targeted to individuals who otherwise would have to be institutionalized. Virginia offers personal attendant care as a service option under the Consumer Directed-Personal Attendant Services (C-DPAS) Waiver. Under the Consumer-Directed Personal Attendant Services Waiver, services may be furnished only to persons:

1. Who meet the criteria as outlined in Appendix B and are at least 18 years of age;

2. Who are financially eligible for Medicaid;

3. For whom an appropriate, cost-effective Plan of Care can be established;

4. Who are not residents of nursing facilities or homes for adults and adult foster homes licensed by DSS;

5. Who do not have any cognitive impairments and are capable of independently managing personal attendants; and

6. Who have no other or have insufficient community resources to meet the individual's needs.

Personal attendant services must be critical to enabling the individual to remain at home or in the community rather than being placed in an institution.

The individual's need for personal attendant services is determined by the NHPAST. A request for a pre-admission screening for nursing facility placement can be initiated by the individual who desires the requested care, a family member, a physician, the local health department or a social services professional, or any other concerned individual in the community. The appropriate assessment instrument, the Uniform Assessment Instrument (UAI), must be completed in its entirety.

The Nursing Home Pre-Admission Screening packet consists of the following items:

- A complete Uniform Assessment Instrument (UAI-12 pages);
- The screening team authorization (DMAS-96);
- The screening team plan of care (DMAS-97);
- The DMAS-95 C-DPAS Addendum;
- The DMAS-20 (Consent to Release Information); and
- The NHPAST decision letter.

See the "Exhibits" section at the end of the chapter for samples of the forms listed above.

The Screening Team Plan of Care indicates the services needed, any special needs of the individual and environment, and the support available to provide services. The Screening Team will note the number of days per week that care is needed but will not authorize the amount of service each day. The Screening Team Plan of Care also serves as written notification to the individual of the estimated patient pay responsibility, when this information is available at the time of the screening, and documents the individual's choice of long-term care options and choice of provider. If personal attendant services are authorized and there is more than one approved provider in the community willing and able to provide care, the individual must have the option of selecting the provider of his or her choice.

The decision of the Nursing Home Pre-Admission Screening Team may be appealed to the Department of Social Services (DSS) Contact the local DSS for information on this appeals process.

PATIENTS WITH COMMUNICABLE DISEASES - WAIVER SERVICES

Services facilitators are prohibited from discriminating against individuals who have been diagnosed as having AIDS and other communicable diseases. Virginia offers a range of home- and community-based care services, which include personal/respite care, through an approved waiver for individuals with AIDS or AIDS Related Complex (ARC). The

Nursing Home Pre-Admission Screening Team and HIV Outpatient Clinics contracted with DMAS to perform screening assessments for the AIDS Waiver, are responsible for the completion of assessments and the authorization of services through the AIDS Waiver. The authorization for personal attendant services will not be made solely on diagnosis. The NHPAST will consider the appropriateness of the service based upon the stage of the disease process and the capability of the provider to adequately staff the individual's care.

AUTHORIZATION FOR MEDICAID PAYMENT OF PERSONAL ATTENDANT SERVICES

Screening and pre-authorization of personal attendant services by the NHPAST is mandatory before Medicaid will assume payment responsibility for personal attendant services.

Medicaid will not pay for any personal attendant services delivered prior to the authorization date of the NHPAST physician's signature on the DMAS-96 approved by the Pre-Admission Screening Team. The date of this authorization cannot be prior to the date on which the assessment is completed and the Screening Team makes a decision.

Medicaid will assume payment responsibility for personal attendant services only after DSS has determined that the individual is financially eligible for medical assistance for the dates services are to be provided.

PREAUTHORIZATION PROCESS

Preauthorization for Consumer Directed-Personal Attendant Services Waiver enrollments is conducted by WVMI, the DMAS contractor. WVMI reviews all preauthorization requests, including enrollments and telephonic inquiries. Consumer-Directed (CD) Services Facilitators have an option of submitting all preauthorization requests to WVMI either telephonically, via facsimile, or by mail. Facsimile is preferred to provide for an efficient process and quick turnaround time. Initial enrollments must be faxed or mailed. Any other requests may be received by telephone, fax, or mail.

Telephonic Preauthorization

To initiate a telephonic request, the CD services facilitator can call WVMI directly and provide the information requested by the analyst. While on the line, the analyst will approve, deny, or pend the request for additional information. The status of the request will be known before the call is completed. All initial telephonic requests, as well as any information submitted in response to pend letters, must be directed to WVMI. Additionally, the provider will need to verify that the required documentation and justification exists in accordance with federal and state regulations, and DMAS published criteria, policy, and procedures. Fully completed plans of care and appropriate justification of services will be verified upon DMAS post payment review audit and may be requested by WVMI for preauthorization determination. In addition to verbal confirmation of the decision, WVMI will send a written validation that will include a 9-digit tracking number. You may contact WVMI at:

(804) 648-3159 Richmond
1-800-299-9864 All Other Areas

Requests by Facsimile

To submit a request by facsimile, all necessary documentation must be sent with the fax cover sheet, located at the end of this chapter under "Exhibits". Fax requests to:

(804) 648-6692 All Areas
1-866-510-7074 All Areas

Mail Requests

To submit information via mail, use WVMI's address below.

WVMI
Attn: CBC Review
6802 Paragon Place – Suite 410
Richmond, VA 23230

If services are denied by the WVMI analyst and the provider wants to request reconsideration of the denial, the provider must proceed with the following reconsideration process. If a telephonic request is denied, the provider may either request telephonic or written reconsideration from the WVMI Preauthorization Supervisor within 30 days of receipt of the date of the denial. The WVMI Preauthorization Supervisor has the option of requiring written reconsideration of a telephone preauthorization request. If a written request is denied, the provider must submit a letter to the WVMI Preauthorization Supervisor requesting reconsideration within 30 days of receipt of the notice.

Upon completion of the reconsideration process, the denial of services not yet rendered may be appealed in writing by the Medicaid individual within 30 days of receipt of the written notification of denial. If the denial is for a service that has already been rendered, the provider may appeal the adverse decision in writing within 30 days of receipt of the written notification of denial of the reconsideration. All written appeals must be addressed to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

FORMS REQUIRED FOR ADMISSION TO PERSONAL ATTENDANT SERVICES

The Nursing Home Pre-Admission Screening Team initiating a referral will first notify the services facilitator that the individual has chosen his or her provider for services to determine whether the provider is able to initiate services promptly for the individual. If the provider can accept the referral, the NHPAST will send the provider a complete packet required for the provider to admit the individual to services.
If the services facilitator does not receive an entire, fully completed packet of referral forms, as noted below, from the NHPAST, the services facilitator must notify the responsible NHPAST and request the completed packet. A provider will not be reimbursed for services until WVMI receives the packet of information completed by the NHPAST, along with the provider's Plan of Care showing the start of care date. (The start of care date is the services facilitator's initial visit date.)

The forms that must be completed by the NHPAST and forwarded to the services facilitator are:

- A completed assessment instrument: UAI (Uniform Assessment Instrument) pages 1-12;
- The original Nursing Home Pre-Admission Screening Authorization (DMAS-96). The authorization must be completed for personal attendant services and must be signed and dated by the physician prior to the start of services;
- The original Questionnaire to Determine a Person's Ability to Independently Manage a Personal Attendant (DMAS-95 Addendum);
- The original of the NHPAST Plan of Care (DMAS-97). This form must be completed in its entirety including the documentation of Freedom of Choice; and
- The Consent to Exchange Information (DMAS-20).

Services facilitators are responsible for reviewing the individual's Medicaid card or calling the toll-free eligibility verification number (1-800-884-9730) to confirm the individual's Medicaid eligibility status prior to the start of care. The services facilitator should contact that individual's eligibility worker at the local DSS prior to the start of care to receive assurance that the individual's services will be covered.

Screening Teams will make personal attendant service referrals only to providers that have met Medicaid requirements and are enrolled under contract as a Medicaid services facilitator.

SERVICES FACILITATOR RESPONSE TO A REFERRAL

Services facilitators shall not begin services for which they expect Medicaid reimbursement until the admission packet is received from the NHPAST and not before the date authorized by the NHPAST on the DMAS-96.

Upon receipt of a referral and prior to the delivery of services, the services facilitator must make a comprehensive evaluation visit to the individual's home. During the

comprehensive home visit, the consumer-directed services facilitator is responsible for the following activities:

- Discussion of the individual's needs and review of the Plan of Care developed by the NHPAST; and

- Completion of the Service Coordination Agency Plan of Care (DMAS-97B) and reviewing this Plan of Care with the individual to ensure that there is a complete understanding of the services that will be provided. The DMAS-97B (see Appendix C) must be completed with the individual's name, 12-digit Medicaid number, provider name and number, Plan of Care needs, start of care date, and consumer-directed services facilitator signature. A copy of the current Plan of Care must be kept in the individual's home. The personal attendant should be instructed by the individual to use the Plan of Care as a guide for daily service provision. The recipient's backup support must also be identified on the DMAS-97B.

The evaluation visit must be documented in the consumer-directed services facilitator's notes as the comprehensive assessment. The comprehensive assessment must document the following:

- Completion and review of the individual's Plan of Care with the individual; and

- Complete assessment to include the individual's current functioning status, medical nursing need, current medications, social support system, other community services rendered to the individual, and the condition of the individual's environment. When any special maintenance care (e.g., administration of bowel program, range of motion exercises, or routine wound care) is to be provided by the personal attendant, the consumer-directed services facilitator must check to make sure that a physician order is present and indicate in the consumer-directed services facilitator note what care the attendant is providing, what instructions that the attendant has received from the (RN) consumer-directed services facilitator regarding this care, and observation of the attendant's demonstration of the correct techniques involved in this care.

It is the consumer-directed services facilitator's responsibility to determine whether service coordination can adequately be provided to an individual prior to accepting a referral for services from a NHPAST. There may, however, be instances where the services facilitator is unaware of a problem that will prohibit service delivery until the services facilitator completes the initial assessment.

RESPONSE TO INAPPROPRIATE AUTHORIZATION

The consumer-directed services facilitator should not initiate services if, during the initial assessment, the provider determines that the services are not appropriate for the health and

safety concerns, the individual does not meet the criteria for the program, or the individual is unable to adequately hire, train, and supervise personal attendants. The consumer-directed services facilitator must notify the individual, in writing, of this decision, include

in detail the reason for the decision and the effective date of this action, and give the individual the right to reconsideration (as outlined in Chapter V). Copies of the letter must be sent to the Nursing Home Pre-Admission Screening Team and WVMI. The services facilitator will send the original screening papers back to the NHPAST. If the individual decides to request a reconsideration, the services facilitator will need to submit to WVMI the documentation of the initial visit that thoroughly documents the reason why services were not provided to the individual and a complete copy of the Pre-Admission Screening Packet.

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action that includes the termination or suspension of the provider agreement.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, an informal conference, and a formal evidentiary hearing. The provider will have 30 days from the date of receipt of the notice to submit information for written reconsideration and will have 30 days to request an informal conference and a formal evidentiary hearing once the reconsideration decision is rendered.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act. Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

ADMISSION CERTIFICATION PROCESS FOR INDIVIDUALS OF CONSUMER-DIRECTED SERVICES

The provider is required to submit to WVMI an enrollment packet that consists of a copy of the Admission Packet (UAI, DMAS-95 Addendum, DMAS-96, and DMAS-97) along with the consumer-directed services facilitator Plan of Care (DMAS-97B), and DMAS-122 with the patient pay amount before the services facilitator may bill for the services rendered. The services facilitator will retain the original items. If an enrollment is received at WVMI and the DMAS-122 does not have a patient pay calculation from DSS, WVMI will pend the request, and the services facilitator will receive a letter from WVMI. This letter must be must be forwarded by the services facilitator to the receipt's local DSS

eligibility worker. The eligibility worker will complete the DMAS-122 including the patient pay and send it to the services facilitator, who will forward the completed DMAS-

122 to WVMI to address the pend status of the recipient's admission. A copy of the "C-DPAS Authorization Form" is at the end of this chapter.

Send C-DPAS Waiver enrollment packets to the following address:

WVMI
Attn: CBC Review
6802 Paragon Place – Suite 410
Richmond, Virginia 23230

Mail the C-DPAS Waiver enrollment packets to WVMI. This envelope must only be used for individual enrollment packets. Do not include any other correspondence or invoices in this envelope. An analyst will be responsible for ensuring the accuracy of all forms submitted for individual enrollment as well as ensuring that level of care criteria and appropriateness of personal attendant services have been met. For any packet received that is incomplete or incorrectly submitted, the provider will be notified. Do not submit the enrollment package without the individual's Medicaid number.

When all of the information is received and reviewed, the authorization will be entered into the First Health computer system for the approved number of hours. The approved number of hours entered is from the Services Coordination Agency Plan of Care (DMAS-97B). Incomplete enrollment packets will be rejected and the provider notified accordingly. After the enrollment authorization is entered into the DMAS computer system, the provider will receive a computer-generated letter confirming that the individual is enrolled in the Medicaid system for payment of personal attendant services. The individual cannot hire a personal attendant and begin receiving attendant services until this letter is received.

PLAN OF CARE FOR CONSUMER DIRECTED-PERSONAL ATTENDANT SERVICES

The DMAS-97B must be completed by the services facilitator prior to or on the date of the start of care for any individual. The NHPAST Plan of Care indicates to the consumer-directed services facilitator the general needs of the individual in eight service needs areas. The services facilitator should allocate time for the four service categories (which include 13 personal attendant tasks) listed on the CD services facilitator Plan of Care, consistent with the specific needs of the individual according to the functioning and medical information included in the Uniform Assessment Instrument and the consumer-directed services facilitator's initial comprehensive visit, any special considerations for service provision, and the support available to the individual. Time should be allocated for each of the 13 tasks on the Plan of Care in accordance with the Personal Care Activities of Daily Living Guideline, which can be found in Appendix B.

Each individual is designated a level of care based on his or her ADL score. The composite ADL score is the sum of a rating of six ADL categories. These six categories

are a composite of 10 of the functional status items on the UAI (bathing, dressing, toileting, continency of bowel, continency of bladder, transferring, mobility, wheeling, walking, and eating/feeding). The provider should assign a rating for each ADL category which best describes the individual based on the information on the UAI and the consumer-directed services facilitator's observation at the time of the initial home evaluation. The scoring is as follows.

The rating of functional dependencies on the pre-admission screening assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. The following abbreviations shall mean:

I = independent
d = semi-dependent
D = dependent

MH = mechanical help
HH = human help

(1) Bathing			**(2) Dressing**		
(a)	Without help	**(I)**	(a)	Without help	**(I)**
(b)	MH only	**(d)**	(b)	MH only	**(d)**
(c)	HH only	**(D)**	(c)	HH only	**(D)**
(d)	MH and HH	**(D)**	(d)	MH and HH	**(D)**
(e)	Is bathed	**(D)**	(e)	Is dressed	**(D)**
			(f)	Is not dressed	**(D)**

(3) Toileting			**(4) Transferring**		
(a)	Without help day or night	**(I)**	(a)	Without help	**(I) (d)**
			(b)	MH only	
(b)	MH only	**(d)**	(c)	HH only	**(D)**
(c)	HH only	**(D)**	(d)	MH and HH	**(D)**
(d)	MH and HH	**(D)**	(e)	Performed by others	**(D)**
(e)	Performed by others	**(D)**	(f)	Is not preformed	**(D)**

(5) Bowel Function			**(6) Bladder Function**		
(a)	Continent	**(I)**	(a)	Continent	**(I)**
(b)	Incontinent less than weekly	**(d)**	(b)	Incontinent less than weekly	**(d)**
(c)	External/In-dwelling device/ Ostomy self-care	**(d)**	(c)	External device self-care	**(d)**
(d)	Incontinent weekly	**(D)**	(d)	Indwelling	**(d)**

	or more			catheter self-care	
(e)	Ostomy not self-care	**(D)**	(e)	Ostomy self-care	
			(f)	Incontinent weekly or more	**(d) (D)**
			(g)	External device, not self-care	**(D)**
			(h)	Indwelling catheter, not self-care	**(D)**
			(i)	Ostomy not self-care	**(D)**

(7) Eating/Feeding			**(8) Behavior Pattern and Orientation**		
(a)	Without help	**(I)**		(a) Appropriate or Wandering/ Passive less than weekly + Oriented	**(I)**
(b)	MH only	**(d)**		(b) Appropriate or Wandering/Passive < weekly + Disoriented Some Spheres	**(I)**
(c)	HH only	**(D)**		(c) Wandering/Passive Weekly or more + Oriented	**(I)**
(d)	MH and HH	**(D)**		(d) Appropriate or Wandering/Passive < weekly + Disoriented All Spheres	**(d)**
(e)	Spoon fed	**(D)**		(e) Wandering/Passive Weekly some or more + Disoriented All Spheres	**(d)**
(f)	Syringe or tube fed	**(D)**		(f) Abusive/Aggressive/ Disruptive< weekly + Oriented or Disoriented	**(d)**
(g)	Fed by IV or clysis	**(D)**		(g) Abusive/Aggressive/ Disruptive weekly or more + Oriented	**(d)**
				(h) Abusive/Aggressive/ Disruptive + Disoriented All Spheres	**(D)**

(9) Joint Motion (NF)			**(10) Mobility**		
(a)	Within normal limits	**(I)**	(a)	Goes outside without help	**(I)**
(b)	Limited motion	**(d)**	(b)	Goes outside MH only	**(d)**
(c)	Instability corrected	**(I)**	(c)	Goes outside HH only	**(D)**
(d)	Instability uncorrected	**(D)**	(d)	Goes outside MH and HH	**(D)**
(e)	Immobility	**(D)**	(e)	Confined moves about	**(D)**
			(f)	Confined does not move about	**(D)**

(11) Medication Administration (NF)			**(12) Medication Administration (ACR)**		
(a)	No medications	**(I)**	(a)	Without assistance	**(I)**
(b)	Self-administered, monitored < weekly	**(I)**	(b)	Administered,	**(D)**
(c)	By lay persons administered/ monitored	**(D)**	(c)	monitored by lay person Administered, monitored by professional staff	**(D)**
(d)	By licensed/ professional nurse administered/ monitored	**(D)**			

(13) Behavior Pattern			**(14) Instrumental Activities of Daily Living (ACR)**		
(a)	Appropriate	**(I)**	(a)	Meal Preparation	
(b)	Wandering/ passive less than weekly	**(I)**		(1) No help needed	
(c)	Wandering/ passive weekly or more	**(d)**		(2) Needs help	**(D)**
			(b)	Housekeeping	
				(1) No help needed	
				(2) Needs help	**(D)**
			(c)	Laundry	

(d)	Abusive/ aggressive/ disruptive less than weekly	**(D)**
(e)	Abusive/ aggressive/ disruptive weekly or more	**(D)**

	(1) No help needed (2) Needs help	**(D)**
(d)	Money Management (1) No help needed (2) Needs help	**(D)**

Once the individual's composite score is derived, a level of care is designated for that individual as either Level A, B, or C. The level of care will assist the consumer-directed services facilitator by indicating the average amount of care needed for individuals with similar needs. However, the Level of Care does not restrict the consumer-directed services facilitator to the designated number of hours per week. The Plan of Care must be developed to meet the needs of the individual. The maximum allowable hours per week on a plan of care is 42.

Reimbursement for the full amount of services included in the Plan of Care and rendered by the personal attendant may be denied when the individual's Plan of Care is inflated beyond the needs of the individual. The determination that a Plan of Care is "inflated" will be based on the pattern of utilization in the geographical locality and within the agency, and on whether the analyst has previously addressed appropriate time frames with the services facilitator.

Level of Care A—The individual scores between 0-6 on the ADL composite rating. Individuals in Level of Care A are the most functionally capable group in personal attendant care and, therefore, should usually require the least amount of services (anywhere from 7.5 to 17.5 hours per week). Within the level of care, the amount of time required to perform ADL and IADL tasks will vary.

The following guidelines are intended to assist the provider when determining the appropriate allocations of ADL time for individuals within Level of Care A. All individuals in Level A probably require more time for IADL tasks since they are more likely to live alone and occupy more living area.

1. Minimal Needs—These are the least dependent individuals, often borderline in meeting the criteria for nursing facility care (ADL score 2-3). The individual may require prompting rather than hands-on assistance, and may use mechanical help more than human help with a need for stand-by assistance:

   Average time allocated for ADL's—.75 - 1 hr/day
   Average time for Housekeeping—1 - 1.5 hr/day

2. Average Needs—These individuals have somewhat more need for hands-on help and stand-by assist and are somewhat more dependent (ADL score 3-4):

Average time allocated for ADL's—1 - 1.5 hr/day
Average time for Housekeeping—1 - 1.5 hr/day

3. Heavy Needs—These individuals will require some help in all areas of ADL care although they will usually be mobile and can probably eat without assistance (ADL score 4-6):

   Average time allocated for ADL's—1.5 - 2 hr/day
   Average time for Housekeeping—1 - 1.5 hr/day

Level of Care B—The individual scores between 7-12 on the ADL composite rating. Individuals in Level of Care B are the least functionally capable group without skilled medical/nursing needs in personal attendant care. These individuals will require an average of from 15 to 28 hours per week. Within the level of care, the amount of time required to perform ADL and IADL tasks will vary.

The following guidelines are intended to assist the provider when determining the appropriate allocations of ADL time for individuals within Level of Care B. Individuals in Level B probably require somewhere between the heavy time allocated in Level A and an average amount of time for IADL tasks, since the population in Level B will have more individuals who have a live-in caregiver and who occupy less living area.

1. Minimal Needs—These individuals may require assistance to ambulate but are still able to perform some tasks for themselves (ADL score 7-8):

   Average time allocated for ADL's—1.5 - 2 hr/day
   Average time for Housekeeping—1 - 1.75 hr/day

2. Average Needs—These individuals may require an assist with transferring as well as ambulating, eating, toileting, and most ADL's (ADL score 9-10):

   Average time allocated for ADL's—2 - 2.5 hr/day
   Average time for Housekeeping—1 - 1.75 hr/day

3. Heavy Needs—These individuals will require the maximum amount of help in all areas of ADL care. They will usually be bed-confined and, therefore, may actually require less time for services than the individual who performs some self-care but requires assistance (ADL score 11-12):

   Average time allocated for ADL's—1.5 - 2.5 hr/day
   Average time for Housekeeping—1 - 1.75 hr/day

Level of Care C—The individual scores 9 or more on the ADL composite rating and in addition requires heavy care and has a skilled need (e.g., wound care; specialized feeding; rehabilitation for paralysis/paresis, quadriplegia/paresis, bilateral hemiplegia/paresis; multiple sclerosis). Individuals in Level of Care C are the least functionally capable group

with skilled medical/nursing needs. These individuals will require an average over 20 hours personal attendant care per week. Within the level of care, the amount of time required to perform ADL and IADL tasks will vary.

The following guidelines are intended to assist the provider when determining the appropriate allocations of ADL time for individuals within Level of Care C. Individuals in Level C probably require the least amount of time for IADL tasks, since the population in Level C may have a live-in caregiver who will perform most of the IADL tasks.

1. Minimal Needs—These individuals may have the maximum in-home support and fewer special maintenance needs. Some of the individuals in this minimum range of needs within Level C will actually be quite dependent but may be cared for quickly, merely because they do not participate in their own care.

   Average time allocated for ADL's—1.5 - 2 hr/day
   Average time for Housekeeping—1 - 2 hr/day

2. Average Needs—These individuals will generally require more ADL time to prevent skin breakdown by frequent turning, may require wound care or feedings completed by the family, etc., and have only moderate support to assist with this care:

   Average time allocated for ADL's—2 - 3 hr/day
   Average time for Housekeeping—1 - 2 hr/day

3. Heavy Needs—These individuals may be new quadriplegics or have a degenerative disease, and they generally are the most difficult individuals to maintain in their homes due to their many maintenance needs:

   Average time allocated for ADL's—2 - 3 hr/day
   Average time for Housekeeping—1 - 2 hr/day

It is important to recognize that the guidelines provided reflect how WVMI will review Plans of Care for each individual based on a general profile of individuals who will typically fall within these Levels of Care. However, since the Level of Care does not reflect the medical needs of the individual, as per his or her diagnosis and recent history, or the idiosyncrasies of that individual's personality or environment, these guidelines cannot fully capture the range of needs and support which the provider may encounter. For instance, housekeeping needs will vary according to the abilities of the individual as reflected in the Level of Care and according to the amount of social support received from either a live-in caregiver or some other family or community support. Other factors, such as the presence of on-site laundry facilities, or the lack of modern plumbing, heating and cooking facilities, will also determine the amount of time required for housekeeping.

The provider is expected to use his or her professional judgment to determine the amount of service needed by the individual. DMAS will receive reports that will summarize

individual utilization and Levels of Care for providers and geographic localities. DMAS will review these reports for any exceptions to patterns of normal utilization.

RESPONSIBILITIES OF THE SERVICES FACILITATOR FOR MONITORING OF INDIVIDUAL SERVICES

The provider is responsible for monitoring the ongoing provision of services to each Medicaid individual. This monitoring includes:

- The quality of care received by the individual;
- The functional and medical needs of the individual and any modification necessary to the Plan of Care due to a change in these needs; and
- The individual's need for support in addition to the care provided by personal attendant services. This includes an overall assessment of the individual's safety and welfare in the home with personal attendant services.

Consumer-Directed Services Facilitator Responsibilities

1. Comprehensive Visit: The consumer-directed services facilitator is responsible for initiating services with the individual upon accepting the referral of service from the Nursing Home Pre-Admission Screening Team. The consumer-directed services facilitator must make an initial comprehensive in-home visit prior to the start of care for any new individual admitted to consumer-directed personal care services. During the visit, the consumer-directed services facilitator will develop a safe, appropriate, and cost-effective Plan of Care with the individual that will meet the medical and social needs of the individual. If the individual requires assistance with bowel or bladder care or both, range of motion exercises, routine wound care, and catheter care, the consumer-directed services facilitator will need to review the personal attendant's ability to perform the tasks required by the individual (see page 22).

   The consumer-directed services facilitator will also provide the individual with a copy of the *Employee Management Manual* (see Appendix C). The consumer-directed services facilitator will ensure that the individual understands his or her rights and responsibilities in the program and sign all of the participation agreements found in the *Employee Management Manual* (including those related to the Selection of Service, Fiscal Agent, and consumer-directed services facilitator). These forms must be signed before the individual can begin employing personal attendants in the program. The consumer-directed services facilitator shall send the original Fiscal Agent Contract to DMAS and keep a copy for the individual's file. **All forms must be signed and dated by the attendant and services facilitator at the time of this visit.**

2. Consumer (Individual) Training: Upon successful completion of the comprehensive visit, the consumer-directed services facilitator must provide the individual with consumer training within seven days of the completion of the comprehensive visit, the consumer-directed services facilitators can complete the comprehensive visit and consumer training in the same day. During the consumer training, the services facilitator must train the individual on his or her duties as employer in the Consumer Directed-Personal Attendant Services Program. To assure that the training content for Individual Management Training meets the minimum acceptable requirements, the consumer-directed services facilitator must follow the checklist for Consumer-Directed Recipient Comprehensive Training form. This is an outline of the minimum subjects that DMAS requires the services facilitator to cover during the training. The services facilitator must check each subject on the form after it has been covered, and have the required signatures and dates. This form must be maintained in the recipient's file and available for review by DMAS staff. This form can be obtained from the DMAS website. An example of this form is in the "Exhibits" section at the end of this chapter. Regardless of the method of training received, documentation must indicate that training was received prior to the individual's employment of a personal attendant.

3. 30-90 Day Routine (Onsite) Visits: After the comprehensive visit, the consumer-directed services facilitator must conduct two onsite routine visits within 60 days of the initiation of care (once per month) to monitor the individual's Plan of Care and ensure both the quality and appropriateness of the services being provided. After the first two routine onsite visits, the consumer-directed services facilitator and individual can decide how frequent the routine onsite visits will be. The consumer-directed services facilitator is responsible for conducting routine onsite visits to the individual's home every 30-90 days, for providing any necessary supervision to the individual, and for recording all significant contacts in the individual's file.

   During visits to the individual's home, the consumer-directed services facilitator must observe, evaluate, and document the adequacy and appropriateness of the personal attendant services with regard to the individual's current functioning status, medical and social needs, and the established plan of care. The personal attendant's record may be reviewed, and the individual's satisfaction with the type and amount of service must be discussed.

   The consumer-directed services facilitator's documentation of this visit may be in the form of a SOAP note (*Subjective* information obtained from the recipient, *Objective* information observed or gathered by the services facilitator, *Assessment* as to what can be determined from the subjective and objective information, *Plan* what the best plan is for the recipient), or the consumer-directed services facilitator may use a standardized form to record the 30-90 day routine visit. Appendix C contains an example of the Consumer Directed-Personal Attendant Services Individual Assessment Report (DMAS-99B). The consumer-directed services facilitator must document:

- Any change in the previously documented individual's medical condition, functioning status, and social support. The consumer-directed services facilitator is expected to know the nursing facility criteria in Appendix B and to apply these criteria when assessing whether the individual continues to meet the criteria to receive personal attendant services. If the consumer-directed services facilitator determines that the individual does not meet the criteria for personal attendant services, the consumer-directed services facilitator supervisor must terminate services as per the instructions in Chapter V;

- Whether the Plan of Care is adequate to meet the individual's needs and whether changes need to be made;

- Dates of and reasons for any service lapses (hospitalization admission and discharge dates, attendant not available, etc.);

- The presence or absence of the attendant in the home during the visit;

- Any time the permanently assigned attendant(s) changes. The consumer-directed services facilitator must note this in the individual's file and ensure that the criminal history record check is performed; and

- A review of individual time sheets. The consumer-directed services facilitator must review the personal attendant time sheets, which are submitted biweekly by the individual, to determine whether the attendant and individual are recording the approved number of hours. If a discrepancy occurs, the consumer-directed services facilitator should notify the Fiscal Agent.

In addition to the routine information that must be documented in the consumer-directed services facilitator's routine visit summary, there are several areas that require special documentation by the consumer-directed services facilitator:

A. Bowel and Bladder Programs - A written physician's order in the individual's file must specify the method and type of digital stimulation and frequency of administration, and must be updated annually. The consumer-directed services facilitator must document that the attendant has received special training in bowel program management, has knowledge of the circumstances that require immediate reporting to the RN or consumer-directed services facilitator, and that the RN or consumer-directed services facilitator has observed the attendant performing this function. The attendant's continuing understanding and ability to perform bowel programs must also be documented in the routine visit note.

B. Range of Motion Exercises - The written physician order that indicates the need and extent of range of motion exercises to be performed must be in the

individual's file, and must be updated annually. The consumer-directed services facilitator must document in the individual's record that the attendant has been instructed by the RN consumer-directed services facilitator in the administration of range of motion exercises and that the attendant's correct performance of these exercises has been witnessed and documented by the RN consumer-directed services facilitator. The continued need for range of motion exercises and the monitoring of the attendant's performance of these exercises must be noted in the routine visit note.

C. Routine Wound Care - During each visit, the consumer-directed services facilitator must document the status of the wound and the monitoring of the individual's care.

D. Catheter Care - When routine care of an external condom catheter is to be provided by the personal attendant, the consumer-directed services facilitator must indicate in the initial comprehensive visit note that the attendant is providing condom catheter care and what instructions the attendant has received regarding this care. Documentation must indicate the attendant's ability to perform this procedure.

4. Reassessment Visit: Once every six months, the consumer-directed services facilitator must provide a full assessment of the individual's current medical, functional, and social support status and a complete summary of all services received. Documentation of the 180-day reassessment must include a complete review of the individual's needs and available supports and a review of the Plan of Care. The Reassessment visit needs to be documented on either a DMAS-99 or a SOAP note.

   During visits to the individual's home, the consumer-directed services facilitator shall observe, evaluate, and document the adequacy and appropriateness of personal attendant services with regard to the individual's current functioning and cognitive status, medical and social needs, and the established Plan of Care.

   It is appropriate for the attendant to chart tasks that are not included in the individual's Plan of Care if the individual has a need for the task to be done. The individual should note why this task was performed and whether the need for this task continues to exist. It is then the responsibility of the consumer-directed services facilitator to determine whether there is a need for the task to be included on the Plan of Care on an ongoing basis and make whatever changes are appropriate.

5. Management Training: This training is provided by the consumer-directed services facilitator upon the request of the individual. This may be additional management training for the individual or special training for the personal attendant at the request of the individual. Consumer-directed services

facilitators can provide up to four hours of management training to an individual within any six-month period.

6. Criminal Record Check: All personal attendants employed by individuals in the Consumer-Directed Services Program must complete a criminal record check. Consumer-directed services facilitators assist individuals by submitting the criminal record check forms to the Virginia State Police on behalf of the individual when the individual hires a new personal attendant. Consumer-directed services facilitators will also pay the $15.00 fee for a criminal record check on behalf of the individual, and DMAS will reimburse consumer-directed services facilitators for the cost of the criminal record check for up to six record checks per individual within any six month period of time. The consumer-directed services facilitator will provide the individual with the results of the criminal history record request and document in the individual's record that he or she has been informed of the results of the criminal record check. If the personal attendant has been convicted of crimes described in 12 VAC 30-90-180, the personal attendant will no longer be reimbursed under this program for care provided to the individual effective the date the criminal record was confirmed. The consumer-directed services facilitator is responsible for notifying the Fiscal Agent whenever an attendant is found to have been convicted of any of the crimes listed below.

   Section 32.1-162.9:1 of the Code of Virginia, Chapter 944 of the Acts of Assembly of 1993, and 12 VAC 30-90-180 prohibit nursing facilities from hiring for compensated employment persons who have been convicted of:

   1. Murder;
   2. Abduction for immoral purposes as set out in § 18.2-48 of the Code of Virginia;
   3. Assaults and bodily woundings as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title § 18.2;
   4. Robbery as set out in § 18.2-58;
   5. Sexual assault as set out in Article 7 of Chapter 4 of Title 18.2 (§ 18.2-61 et seq.);
   6. Arson as set out in Article I (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2;
   7. Pandering as set out in § 18.2-355;
   8. Crimes against nature involving children as set out in § 18.2-361;

9. Taking indecent liberties with children as set out in § 18.2-370 or § 18.2-370.1;

10. Abuse and neglect of children as set out in § 18.2-371.1;

11. Failure to secure medical attention for an injured child as set out in § 18.2-314;

12. Obscenity offenses as set out in § 18.2-374.1 or 18.2-379; or

13. Abuse or neglect of an incapacitated adult as set out in § 18.2-369.

Individuals have the right to choose to hire and employ a personal attendant whom they know has been convicted of a crime that is not specified above. When doing so, individuals must understand this decision and that the consequences thereof are their sole responsibility. DMAS will not reimburse for services provided by attendants that do not meet the statutory and regulatory requirements. In making this decision, individuals must sign Appendix J in the *Employee Management Manual,* "Consumer/Employment Acceptance of Responsibility for Employment," in which the individual agrees by employing the personal attendant to hold harmless from any claims and responsibility DMAS, the consumer-directed services facilitator, and the Fiscal Agent. This form must be kept in the individual's file.

7. Personal Attendant Registry

The consumer-directed services facilitator shall maintain a personal attendant registry. The registry shall contain the names of persons who have experience with providing personal attendant services or who are interested in providing personal attendant services. The registry shall be maintained as a supportive source for the individual who may use the registry to obtain the names of potential personal attendants. Although DMAS does not require services facilitators to verify a personal attendant's qualifications prior to enrollment in a registry, the providers may set their own standards regarding the qualifications needed for personal attendants to enroll in their registries.

The consumer-directed services facilitator is responsible for taking appropriate action to assure continued appropriate and adequate service to all individuals. Appropriate actions may include: counseling or training a personal attendant about the care to be provided to the individual (at the individual's request); counseling or training an individual regarding his or her responsibilities as an employer; requesting from WVMI an increase to the individual's Plan of Care as needed; and discussing with the individual the need for additional care for the individual or contacting WVMI to request a special review of the individual's case. Any time the services facilitator is unsure of the action that needs to be taken, the provider should contact WVMI utilization review staff.

Any corrections needed to any documentation should be made by drawing a line through the incorrect entry and reentering the correct information. White-out must never be used for correction. Any corrections made must be initialed and fully dated. Copies of all documentation submitted to WVMI are subject to review by state and federal Medicaid representatives. The records contained in the chart must be current within two weeks at all times.

The services facilitator shall verify biweekly timesheets signed by the individual and the personal attendant to ensure that the approved hours on the POC are not exceeded.

If the individual is unable to sign the time sheets, a family member or friend may sign. If no other person is able to sign the time sheets, the individual may make an "X." If the individual is unable to sign or make an "X," the consumer-directed services facilitator must make a notation in the recipient's record that "individual is unable to sign."

See the section titled "Requests for Billing Materials and All Forms Used by Provider Agencies" in Chapter VI regarding the ordering of forms.

Health and Safety Issues

When the services facilitator becomes aware that the services being provided and the individual's current support system may not adequately provide for the individual's safety, the services facilitator should immediately contact the WVMI review analyst to discuss the case specifics. The purpose of this discussion is to determine whether the individual's current status represents a potential risk or an actual threat to his or her safety, health, or welfare.

A potential risk is identified as a deterioration in either the individual's condition or environment which, in the absence of additional support, could result in harm or injury to the individual.

An actual threat is the presence of a harm or injury to the individual which can be attributed to the individual's deterioration and lack of adequate support (e.g., the individual becomes anemic, malnourished, or dehydrated due to the inability to obtain food and water; the individual develops decubitus due to extended periods of immobility, lying in urine or feces, etc.).

To determine whether an actual threat may exist, the consumer-directed services facilitator should consider the following:

1. Is the individual capable of calling for help when needed?

2. Is there a support system available for the individual to call?

3. Can conditions be arranged for the individual to care for basic needs when the support system is absent?

4. Is the individual medically at risk when left alone (i.e., is the individual falling frequently)?

5. Has some harm or injury to the patient been noted or reported?

6. Does the individual express fear or concern for his or her welfare?

7. Are there other community resources which may provide sufficient assistance to alleviate the risk?

If answers to the above indicate a potential risk, the services facilitator should still advise WVMI of the situation.

When a real threat to the individual's health, safety, or welfare exists, the services facilitator will attempt to assess whether additional services can be obtained to maintain the individual in a home environment. If continued maintenance in the home under C-DPAS is not possible, the analyst will instruct the consumer-directed services facilitator to initiate procedures to terminate services and advise the individual that other community-based care services or nursing facility services should be considered. See Chapter V for the procedures for transferring an individual from consumer-directed personal attendant care to alternative home and community-based care services or nursing facility services.

Changes to the Plan of Care

The services facilitator is responsible for making modifications to the Plan of Care as needed to ensure that the attendant and individual are aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the individual. The services facilitator is able to establish the amount of service in the Plan of Care which is appropriate to meet the individual's needs as long as the maximum number of hours per week does not exceed the level of care authorized by the NHPAST.

Any time the number of hours for an individual needs to be changed, a new consumer-directed services facilitator Agency Plan of Care (DMAS-97B) must be developed and a copy sent to WVMI to ensure the correct amount of hours is entered into the system to allow for correct claims processing. The most recent Plan of Care must always be in the individual's home. The services facilitator does not need to change the Plan of Care to capture minor changes in tasks within categories or days of the week when tasks are to be performed, as long as the number of hours does not change.

The Individual's Inability to Obtain Personal Attendant Services and Substitution of Attendants

During the development of the Plan of Care, the provider shall ensure that the individual has a documented emergency-back-up plan in place. The individual will use the back-up plan in case the personal attendant does not report for work as expected or terminates

employment without prior notice. Back-up support can be provided by an informal network of friends and neighbors who can be called on as needed as long as this ensures the individual's needs are met.

The individual is responsible for recruiting, hiring, training, and firing the personal attendant. If the individual is unable to find an attendant and requests the services facilitator's assistance, the services facilitator shall provide the individual with a list of persons on the provider's personal attendant registry and document the contact in the individual's file. The individual can use this list to find a new attendant or receive temporary assistance until the attendant returns.

An individual's inability to obtain and retain personal attendants to provide services can be a serious threat to the safety and health of an individual who does not have a support system available to provide back-up support. If an individual is consistently unable to hire and retain the employment of an attendant, the services facilitator should discuss transferring to another community-based care waiver. C-DPAS waiver recipients are able to transfer to the AIDS waiver and the E&D Waiver without a new screening.

SERVICES FACILITATOR'S RESPONSIBILITY FOR THE PATIENT INFORMATION FORM (DMAS-122)

The Patient Information form (DMAS-122) is used by the services facilitator and the local DSS to exchange information regarding: the individual's Medicaid eligibility for long-term care and consumer directed-personal attendant services, the responsibility of a Medicaid eligible individual to make payment toward the cost of services, and other information that may affect the eligibility status of an individual. (Appendix C contains a sample of the form and the instructions for its completion.) The provider is responsible for ensuring that a current completed DMAS-122 is in the individual's record. The local DSS generates a new DMAS-122 at least annually. Uses of the DMAS-122 include all of the following. The facilitator is responsible for sending the most current DMAS-122 to the fiscal agent.

Consumer-Directed Personal Attendant Service Initiation

As soon as the services facilitator receives a referral for services, a DMAS-122 must be sent to the eligibility unit of the appropriate local DSS indicating the provider's first date of service delivery. If an enrollment is received at WVMI and the DMAS-122 does not have a patient pay calculation from DSS, WVMI will pend the request, and the services facilitator will receive a letter from WVMI. This letter must be must be forwarded by the services facilitator to the recipient's local DSS eligibility worker. The eligibility worker will complete the DMAS-122 including the patient pay and send it to the services facilitator, who will forward the completed DMAS-122 to WVMI to address the pend status of the recipient's admission. A copy of the "C-DPAS Authorization Form" is at the end of this chapter.

It is advisable for the services facilitator to contact the eligibility worker prior to the start of service for assurance of the individual's Medicaid eligibility for Consumer-Directed Personal Attendant services. The completed DMAS-122 form serves as the provider's authorization to bill for consumer directed-personal attendant services and to provide confirmation that the individual is eligible for long term care services, as well as to identify the individual's financial responsibility toward the cost of services. Services rendered prior to the receipt of the completed DMAS-122 are at risk of non-payment or retraction for either of the following reasons: the individual is found to be ineligible for Medicaid, or the provider bills DMAS for services that are the financial responsibility of the individual as indicated in the patient pay amount. The eligibility worker will return the same DMAS-122 to the provider with the bottom section completed, showing confirmation of the individual's Medicaid identification number, the individual's income, and the date on

which the individual's Medicaid eligibility was effective. A copy of the completed DMAS-122 must be forwarded to WVMI with the initial enrollment packet and maintained in the individual's file.

Patient Pay Amount

Each Medicaid individual recipient of home and community-based care services is allowed to keep a portion of his or her income to meet his or her own maintenance needs. This

maintenance allowance is higher for the individual staying at home in the community-based care program than for the individual in a nursing facility. The maintenance allowance for individuals of consumer directed-personal attendant services is equal to 100% of the current Supplemental Security Income (SSI) individual payment standard.

An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a non-institutionalized individual must be deducted. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. For individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI. For individuals employed at least 8 but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. In no case shall the total amount of income, earned or unearned, be disregarded for maintenance exceeding 300% of SSI.

The maintenance allowance and any other allowable deduction (e.g., medical insurance payments) are deducted from the individual's income to arrive at that individual's patient pay amount. The patient pay amount will be figured into the amount owed to the personal attendant, and the individual will be responsible for giving the personal attendant the patient pay as payment for personal attendant services. The provider is allowed to collect no more than the Medicaid rate for the service provided. Should the patient pay amount equal or exceed the cost of attendant services, the individual will pay the attendant the full cost due for consumer directed-personal attendant services. The personal attendant will be responsible for Internal Revenue Service reporting. DMAS will reimburse the personal attendant for services that are not covered by the patient pay.

The services facilitator must notify and send a copy of the DMAS-122 to WVMI in order for WVMI to enroll the individual in the Consumer Directed-Personal Attendant Services Waiver. The services facilitator will forward the DMAS-122 information to the fiscal agent on enrollment.

Additional Uses of the DMAS-122

It is the responsibility of the services facilitator to notify WVMI and DSS via the DMAS-122 of the consumer-directed services facilitator's last date of service delivery when any of the following circumstances occurs:

- The consumer-directed services facilitator's services are stopped because the individual dies or is discharged (including transfer) or coverage is terminated; or
- Any other circumstances (including hospitalization, except as outlined in Chapter V) which cause the services to cease or become interrupted for more than 30 days.

EXAMPLE: The services facilitator delivered services to an individual through the third of a given month. The individual then was hospitalized and died on the fifteenth. Even though the agency kept the case open to see if the individual would need services post-hospitalization, the date submitted on the DMAS-122 would be the third since this was the provider's last date of service delivery.

It is the responsibility of the services facilitator to assure that a DMAS-122 for the current year is in the individual's record.

CHANGE IN SERVICES BY THE SERVICES FACILITATOR - ADVANCE NOTICE REQUIRED

There are various financial, social, and health factors that might cause a services facilitator to terminate, increase, or decrease services to a Medicaid recipient. The services facilitator is responsible for recommending adjustments to services as indicated by any change in the recipient's needs or situation. The provider must give the recipient five days written notification of any decision to terminate or change the amount of services received (unless the recipient requests a date which is less than five days, and the provider documents that this is according to the recipient's request) and must indicate the specific reason(s) for the decision.

The agency must help the recipient identify and transfer to another provider. The new provider must develop a Plan of Care, complete the DMAS-97B, DMAS-99B, and DMAS-122 with the transferring agency's last date of service (which is the last day the attendant provided services under the services facilitator) and submit it to WVMI for approval. WVMI must be notified the services facilitator is discontinuing services for a transfer or mutual decision.

Termination of Services

Any time the services facilitator determines that an individual does not have functional dependencies or medical/nursing needs that meet the criteria for personal attendant care, the services facilitator must notify WVMI. If WVMI agrees with the services facilitator's decision, then WVMI will terminate enrollment in the waiver and notify the recipient and the provider in a letter, giving the recipient at least ten (10) days notice of termination.

If the recipient's care is terminated by WVMI or DMAS, the services facilitator must send a Patient Information Form (DMAS-122) to the appropriate local Department of Social Services (DSS). The DMAS-122 must note the date of termination as the last date of services rendered. In the event that a recipient's care was terminated and the analyst decides to reinstate services, the services facilitator must send a copy of the analyst's letter reinstating services, along with a DMAS-122, to the local DSS. The services facilitator is responsible for making a reasonable effort to ensure the continuity and appropriateness of care through referrals to any other appropriate sources of assistance.

Decrease in Hours

If the consumer-directed (CD) services facilitator has determined that a decrease in the hours of service is warranted, the CD services facilitator must discuss the decrease in hours with the recipient during a home visit, not by telephone, and document the visit and conversation in the recipient's record. The services facilitator is responsible for developing the new Plan of Care (DMAS-97B) and notifying the recipient by letter. This letter must state the specific reasons for the decrease, the new number of hours to be provided per week, the effective date of the decrease in hours, and the Right to Reconsideration statement. A copy of this letter must be filed in the recipient's record. The services facilitator must send a copy of the revised DMAS-97B and the recipient letter to WVMI.

The recipient may request a reconsideration of this decision by notifying WVMI in writing. The address is:

WVMI
Attn: CBC Review
6802 Paragon Place – Suite 410
Richmond, VA 23230

The written request for a reconsideration must be received within 30 days of the recipient's receipt of the notice. If he or she files the request before the effective date of this action, services may continue during the reconsideration process. If the recipient requests a decrease in hours by phone, the CD services facilitator is not required to make an extra visit

to the recipient's home. The CD services facilitator may send a letter confirming the recipient's request, the new number of hours, and the effective date of the change.

Increase in Hours

The CD services facilitator is able to establish the amount of service in the Plan of Care that is appropriate to meet the recipient's needs, as long as the maximum number of hours per week for that recipient's level of care is not exceeded.

WVMI may authorize the increase in hours by telephone, fax or mail and the services facilitator must note this decision in the recipient's record.

If WVMI does not approve the request to increase the hours, the services facilitator must send a letter to the recipient of WVMI's decision. The letter to the recipient must indicate the reason the change was not made. This letter must also give the recipient notification of his or her right to reconsideration. WVMI will send a copy of this letter to the services facilitator.

TERMINATION OF SERVICE COORDINATION SERVICES BY THE PROVIDER - ADVANCE NOTICE NOT REQUIRED

Service coordination services may be terminated immediately without prior notice by the services facilitator if the provider's personnel are in immediate danger, the recipient requests immediate termination of the services, or the provider does not have staff available to render the services and is not able to transfer the services. This does not include those situations in which the services facilitator has some concerns about the recipient's health or safety. In these situations, the services facilitator should detail to WVMI his or her concerns and continue to provide services pending a decision by the analyst regarding the recipient's continued appropriateness for personal attendant services.

When the services facilitator determines that the recipient or the recipient's environment presents an immediate danger to personnel, WVMI must be notified immediately by telephone. In addition, a letter must be written by the services facilitator to the recipient stating that services will be or have been terminated. This letter must state the effective date of termination and an accurate statement regarding the reason for termination by the services facilitator. The services facilitator will advise the recipient to contact another approved services facilitator for continued services. A copy of the letter must be filed in the recipient's record and a copy of the letter with a DMAS-122 (Patient Information Form) (with the last day of service) must be sent to the CBC Review Section of WVMI. A copy of the DMAS-122 must be sent to the appropriate local DSS, giving the termination date as the last date of service rendered.

TERMINATION OF PERSONAL ATTENDANT SERVICES BY WVMI

WVMI may terminate personal attendant services for any of the reasons stated below, or for any other reason that might apply:

- Personal attendant care is not the critical alternative to prevent or delay institutional placement;
- The recipient no longer meets community-based care criteria;
- The recipient's home does not provide for the recipient's health, safety, and welfare; and
- An appropriate and cost-effective Plan of Care cannot be developed.

WVMI will notify in writing the services facilitator and the recipient if personal attendant care services are to be terminated. The effective date of termination will be at least 10 days from the date of the termination notification letter. The services facilitator will receive a copy of the decision letter sent to the recipient. The recipient has the right to appeal any action taken by WVMI to terminate services. An appeal filed by the recipient prior to the date of termination entitles the recipient to continued services during the appeal process. If, however, the Appeals Division upholds the WVMI decision, the recipient may be required to reimburse Medicaid for all services received following the original date of termination. The services facilitator will be notified by WVMI in the event of an appeal and advised whether to continue previous services and bill Medicaid during the appeal process.

SUSPECTED ABUSE OR NEGLECT

If the services facilitator knows or suspects that the consumer-directed personal attendant care recipient is being abused, neglected, or exploited, § 63.1-55.3 of the Code of Virginia mandates that the party having knowledge or suspicion of the abuse, neglect, or

exploitation report this to the local Department of Social Services (DSS)/Adult Protective Services (APS). DSS is responsible for investigating alleged abuse, neglect, or exploitation.

The contact with the local DSS may be made anonymously, but the personal attendant care record must note the alleged abuse or neglect and state that the appropriate report has been made. The services facilitator must also report the suspicions to WVMI.

MEDICAID APPLICATION PENDING

DMAS cannot reimburse for personal attendant services rendered if:

- The individual has not been assessed through the Nursing Home Pre-Admission Screening (NHPAS) process and determined eligible for waiver services;

- The individual is not financially Medicaid-eligible on the dates that services are rendered; and

- The individual has not received services that are covered under personal attendant care as defined by DMAS.

There will be cases in which the individual has been assessed and approved for services through NHPAS but final financial Medicaid eligibility has not been determined. In these cases, the services facilitator may wish to provide services, as approved by NHPAS, while awaiting the final eligibility decision by the local DSS regarding Medicaid financial eligibility. The provider cannot bill and is not guaranteed Medicaid reimbursement for services provided until the provider verifies that Medicaid has been approved via a DMAS-122 from the local DSS or by viewing the recipient's Medicaid card or by calling the Audio Response System (ARS) line.

If the individual is determined to be financially Medicaid-eligible, the date of Medicaid financial eligibility may be retroactive (i.e., the effective eligibility date established is prior to the date of approval of the Medicaid application).

DMAS will reimburse the CD services facilitator to the retroactive date of eligibility if, and only if, all DMAS personal attendant care regulations and policies have been followed. The CD services facilitator must have all NHPAS forms, a DMAS-97B, CD services facilitator visit notes, and personal attendant/recipient time sheet documentation. DMAS will not reimburse for the following services:

- Those that cannot be verified in the CD services facilitator notes;

- Those which were rendered prior to the date of authorization and physician certification on the DMAS-96; or

- Those that were rendered prior to the effective date of financial Medicaid eligibility.

If the individual who has been screened for the C-DPAS waiver does not have a Medicaid ID number, the services facilitator must follow the procedures outlined below:

1) The services facilitator must send a copy of the NHPAST screening to DMAS, Waiver Services Unit with a letter requesting review for waiver eligibility.

   DMAS will review the NHPAST screening and determine if the individual meets the level of care criteria. DMAS will send a letter to the services facilitator with the results of the review. If the individual meets the level of care criteria, DMAS will send the services facilitator a letter with its decision. The DMAS letter is not a letter of authorization for waiver services, but confirmation that the individual meets waiver level of care criteria.

2) The services facilitator must include a copy of the DMAS review letter to the DSS eligibility worker. The eligibility worker will issue a Medicaid ID number, along with a completed DMAS-122, with the patient pay, to the services facilitator.

3) Once the services facilitator receives the DMAS-122 with the patient pay amount, the services facilitator must send the DMAS-122 with the entire admission packet to WVMI requesting authorization of waiver services.

ADDITIONAL SERVICES - NON-PERSONAL ATTENDANT CARE

A recipient may desire additional services above and beyond the services provided by consumer-directed personal attendant care which the family or other support system is unable to provide. "Additional services" are defined as those tasks not covered by personal attendant care, such as companion care (for an individual who does not require 24-hour care) and heavy household cleaning. This additional care may be purchased by the recipient or family from any source, including the services facilitator, or provided through other programs.

The services facilitator's record must contain reference to any other service(s) received by the recipient regardless of the source of payment. However, a provider that provides more than one service to an individual should ensure that the documentation of each service is maintained separately. These services are not reimbursed by DMAS.

REFUSAL OF PERSONAL ATTENDANT SERVICES BY THE RECIPIENT

Recipients have the right to refuse services. This refusal must be documented by the CD services facilitator during routine visits. If services are refused frequently, a reduction in hours may be warranted (see the section above entitled, "Decrease in Hours").

HOSPITALIZATION OF RECIPIENTS

When a recipient is hospitalized, the CD services facilitator should contact the hospital discharge planner or hospital social services department to facilitate discharge planning. If the recipient will not be returning to the home with consumer-directed personal attendant services, the services facilitator is instructed to terminate services and send a DMAS-122 to the local DSS and WVMI, indicating the last date that the individual received services. Services facilitators will not be reimbursed for services while the recipient is hospitalized.

When a recipient is hospitalized, regardless of the length of stay in the hospital, and the services facilitator is able to ascertain that the recipient continues to meet the waiver criteria and requires the resumption of personal attendant care services, the provider will resume service without an additional pre-admission screening. (If a change in hours is indicated, see the sections above entitled, "Decrease in Hours" and "Increase in Hours.")

LAPSE IN SERVICE, OTHER THAN FOR HOSPITALIZATION - 30 DAYS OR MORE

The services facilitator must report to DSS any recipient who, for any reason other than hospitalization, does not receive services for 30 days or more. A new screening is not required for a recipient who has been terminated from personal attendant care when both of the following conditions are met:

(a) The date of service resumption occurs within 365 days from the last date of service delivery, and the recipient is requesting services from the services facilitator that provided services prior to the most recent termination. If the recipient is without services within 180 days and continues to meet the waiver criteria, the services facilitator must reopen the case with an initial Comprehensive Visit and send WVMI an updated DMAS-97B, DMAS-99B, and the most current DMAS-122;; and

(b) The consumer-directed services facilitator is able to determine that the recipient continues to meet nursing facility criteria and requires personal attendant services in order to remain in the community.

To re-enroll the recipient in personal attendant services, the consumer-directed services facilitator must:

(1) Conduct a home visit to assess whether the individual continues to meet waiver criteria. Document this information on a DMAS-99B and submit to the WVMI review analyst this full assessment of the recipient's functional and medical status according to definitions and criteria in Appendix D and a DMAS-97B which shows the new effective date, and the most recent DMAS-122 with patient pay information; and

(2) Submit a DMAS-122 to the local DSS indicating the date that services were resumed.

If the CD services facilitator has any concern that the recipient no longer meets the level of care criteria, the CD services facilitator is advised to refer the recipient for a pre-admission screening.

If the recipient requests services from a new provider after a lapse in service that exceeds 365 days, a new pre-admission screening is required. If the recipient is without community-based care waiver services for longer than 180 days, but less than 365 days, the services facilitator must update the pre-admission screening and must complete the following forms:

- Screening Team Service Plan (DMAS-97) if other community-based care services are checked;
- Consumer-Directed Personal Attendant Services Plan of Care (DMAS-97B);
- Consumer-Directed Personal Attendant Services Recipient Assessment Report (DMAS-99B); and
- If appropriate, the DMAS-95 Addendum for C-DPAS services.

NURSING FACILITY OR REHABILITATION FACILITY TO CONSUMER-DIRECTED PERSONAL ATTENDANT CARE

A Uniform Assessment Instrument (UAI), DMAS-96, DMAS-97, and DMAS-95 Addendum for Consumer-Directed Services must be completed by the local Pre-Admission Screening Team in the locality of the nursing facility if the consumer wishes to be discharged home and receive services under the C-DPAS waiver. Since many hospitals have nursing facility and rehabilitation units connected to the hospital, it is important to check with the hospital to ensure that the recipient has been in the acute care portion of the facility prior to resuming consumer-directed personal attendant services without a new screening.

If the recipient has received services under the CDPAS or Elderly and Disabled (E&D) Waivers, a new screening is not needed if the waiver services begin within 365 days of the discharge date from the Nursing Home. The provider agency must update and submit to WVMI with the admission of waiver services a DMAS-99B and DMAS-97B. If the recipient's discharge from a nursing home is over 365 days, a new screening must be done by a local Pre-Admission Screening Team.

If the recipient is discharged from a rehabilitation facility and does not have a current screening, a full screening must be done by the Pre-Admission Screening Team. If the recipient went from either CD or E&D waiver services into a rehabilitation facility and is beginning CD or E&D waiver services, the following rules apply.

- If the date of admission into the rehabilitation facility to the admission date of wavier services is less than 90 days, a new screening is not needed. The provider agency must update the DMAS-97, DMAS-99A or B, or/and DMAS-301 at the initial assessment.

- If the date of admission into the rehabilitation facility to the admission date of wavier services is greater than 90 days, the recipient must have a new screening conducted by the local Pre-Admission Screening Team.

CHANGE OF RESIDENCE

If a recipient's residence changes, the provider agency must record this in the recipient's record and notify the local DSS. This notification must be immediate and in writing.

PROVIDER-TO-PROVIDER TRANSFERS

If a recipient transfers from one provider to another, the transferring provider will send to the new provider the following:

- The originals of the UAI, DMAS-96, DMAS-97, and the DMAS-95 Addendum, along with the most current DMAS-97B;
- A current DMAS-122;
- The most recent utilization review analyst's authorization letter if the hours exceed the maximum for the recipient's level of care;
- Copies of the chart entries pertaining to the recipient's history and current status; and
- A statement or copy of the letter to the recipient giving the date the transferring agency is ending services and the reason for the transfer.

The transferring provider must retain a copy of any material sent to the receiving provider. The receiving CD services facilitator must conduct a comprehensive visit to the recipient prior to the start of care, develop a new agency Plan of Care, and send a copy to WVMI indicating the name of the original provider, the last date of service provided by that provider, the name of the provider receiving the transfer, the effective date of the new provider's Plan of Care, and the DMAS-99B. The receiving provider must also send a DMAS-122 to the local DSS to inform them that a change in provider has occurred. If the hours in the Plan of Care developed by the receiving provider exceed the previously developed Plan of Care, an explanation must be provided.

PERSONAL ATTENDANT CARE TO ELDERLY AND DISABLED WAIVER TRANSFERS

If a recipient decides that he/she would prefer to receive Elderly and Disabled Waiver (E&D Waiver) personal care rather than consumer-directed personal attendant services, the personal care agency or the RN supervisor in the E&D Waiver must complete the DMAS-99 at the initial assessment. The CD services facilitator will assist the recipient with identifying a personal care provider. Once a provider is located, the CD services facilitator will send the original UAI, the DMAS-96, DMAS-97, DMAS-97B, the recipient's signed decision letter, the most recent DMAS-122 with the last date of service, and a cover letter stating this is a transfer recipient to the personal care provider. The CD services facilitator must retain a copy of all materials and forms that are being provided to the E&D personal care provider. The CD services facilitator must also send a DMAS-122 to the local DSS and to WVMI indicating the last date of C-DPAS services.

If a recipient decides that he/she would prefer to receive consumer-directed personal attendant services rather than E&D Waiver personal care services, the CD services facilitator must complete the DMAS-99B at the initial assessment and the DMAS-95 Addendum. The E&D Waiver provider will send the original UAI, the DMAS-96, DMAS-97, DMAS-97A, the recipient's signed decision letter, the most recent DMAS-122 with the

last date of service, and a cover letter stating this is a transfer recipient to the CD services facilitator. The E&D provider must retain a copy of all materials and forms that are being provided to the CD services facilitator. The E&D provider must also send a DMAS-122 to the local DSS and to WVMI indicating the last date of E&D Waiver services.

PERSONAL ATTENDANT CARE TO NURSING FACILITY TRANSFERS

A new pre-admission screening is not required when the recipient in the community and receiving consumer-directed personal attendant services requires admission to a nursing facility. Once a nursing facility bed has been located for the recipient, the CD services facilitator is responsible for updating the DMAS-99B to show the recipient's current functional status and medical/nursing needs. The CD services facilitator must forward this updated DMAS-99B, along with a statement regarding the reason that nursing facility placement is being sought and the nursing facility that has been chosen.

NOTE: If the individual appears to have a condition of MI/MR, a Level II screening may be required.

The provider must notify (via the DMAS-122) the local DSS and the review analyst at WVMI of the date on which personal attendant services were terminated.

Upon review of the information submitted by the CD services facilitator, if DMAS concludes that the recipient does not meet the criteria for nursing facility admission, DMAS will notify the recipient and CD services facilitator that nursing facility admission is denied and will give the reason that the recipient does not meet nursing facility criteria.

EXHIBITS

TABLE OF CONTENTS

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates:
Screen: ____/____/____
Assessment: ____/____/____
Reassessment: ____/____/____

1 IDENTIFICATION/BACKGROUND

NAME & VITAL INFORMATION

Client Name: _____ Client SSN: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____ City/County Code: _____

Directions to House: **Pets?**

Demographics

Birthdate: ____/____/____ **Age:** _____ **Sex:** ____ Male 0 ____ Female 1
(Month) (Day) (Year)

Marital Status: ____ Married 0 ____ Widowed 1 ____ Separated 2 ____ Divorced 3 ____ Single 4 ____ Unknown 9

Race:
____ White 0
____ Black/African American 1
____ American Indian 2
____ Oriental/Asian 3
____ Alaskan Native 4
____ Unknown 9 _____
Ethnic Origin: _____

Education:
____ Less than High School 0
____ Some High School 1
____ High School Graduate 2
____ Some College 3
____ College Graduate 4
____ Unknown 9
Specify: _____

Communication of Needs:
____ Verbally, English 0
____ Verbally, Other Language 1
Specify: _____
____ Sign Language/Gestures/Device 2
____ Does Not Communicate 3
Hearing Impaired? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ Relationships: _____
Address: _____ Phone: (H) _____ (W) _____
Name: _____ Relationship: _____
Address: _____ Phone: (H) _____ (W) _____
Name of Primary Physician: _____ Phone: _____
Address: _____

Initial Contact

Who called: _____
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

Client Name: ***Client SSN:***

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*(Check All Services That Apply)*	Provider/Frequency:
		Adult Day Care	
		Adult Protective	
		Case Management	
		Chore/Companion/Homemaker	
		Congregate Meals/Senior Center	
		Financial Management/Counseling	
		Friendly Visitor/Telephone Reassurance	
		Habilitation/Supported Employee	
		Home Delivered Meals	
		Home Health/Rehabilitation	
		Home Repairs/Weatherization	
		Housing	
		Legal	
		Mental Health (Inpatient/Outpatient)	
		Mental Retardation	
		Personal Care	
		Respite	
		Substance Abuse	
		Transportation	
		Vocational Rehab/Job Counseling	
		Other:	

FINANCIAL RESOURCES

Where are you on the scale for annual (monthly) family income before taxes?

	$20,000 or More	($1,667 or more) 0
	$15,000 - 19,999	($1,250 - $1,666) 1
	$11,000 - 14,999	($ 917 - $1,249) 2
	$ 9,500 - 10,999	($ 792 - $ 916) 3
	$ 7,000 - 9,499	($ 583 - $ 791) 4
	$ 5,500 - 6,999	($ 458 - $ 582) 5
	$ 5,499 or Less	($ 457 or Less) 6
	Unknown 9	

Number in Family unit: _____

Optional: Total monthly family income: _____

Do you currently receive income from…?

No 0	Yes 1		Optional:
		Black Lung	
		Pension	
		Social Security	
		SSI/SSDI	
		VA Benefits	
		Wages/Salary	
		Other	

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1		*Names*
		Legal Guardian	
		Power of Attorney	
		Representative Payee	
		Other	

Do you receive any benefits or entitlements?

No 0	Yes 1	
		Auxiliary Grant
		Food Stamps
		Fuel Assistance
		General Relief
		State and Local Hospitalization
		Subsidized Housing
		Tax Relief

What types of health insurance do you have?

No 0	Yes 1			
		Medicare, #		
		Medicaid, #		
		Pending:	No 0	Yes 1
		QMB/SLMB:	No 0	Yes 1
		All Other Public/Private:		

Client Name:	*Client SSN:*

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
____ House: Own 0				
____ House: Rent 1				
____ House: Other 2				
____ Apartment 3				
____ Rented Room 4				

	Name of Provider *(Place)*	Admission Date	Provider Number *(If Applicable)*
____ Adult Care Residence 50			
____ Adult Foster 60			
____ Nursing Facility 70			
____ Mental Health/Retardation Facility 80			
____ Other 90			

Where you usually live are there any problems?

No 0	Yes 1	*(Check All Problems That Apply)*
_____	_____	Barriers to Access
_____	_____	Electric Hazards
_____	_____	Fire Hazards/No Smoke Alarm
_____	_____	Insufficient Heat/Air Conditioning
_____	_____	Insufficient Hot Water/Water
_____	_____	Lack of/Poor Toilet Facilities (Inside/Outside)
_____	_____	Lack of/Defective Stove, Refrigerator, Freezer
_____	_____	Lack of/Defective Washer/Dryer
_____	_____	Lack of/Poor Bathing Facilities
_____	_____	Structural Problems
_____	_____	Telephone Not Accessible
_____	_____	Unsafe Neighborhood
_____	_____	Unsafe/Poor Lighting
_____	_____	Unsanitary Conditions
_____	_____	Other: _____

Describe Problems:

Client Name: ***Client SSN:***

② FUNCTIONAL STATUS *(Check only one block for each level of functioning.)*

ADLS	Needs Help?	
	No 00	Yes
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40			Is Not D Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
					Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	

Continence	Needs Help?	
	No 00	Yes
Bowel		
Bladder		

Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External D Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6

Ambulation	Needs Help?	
	No 00	Yes
Walking		
Wheeling		
Stairclimbing		
Mobility		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40	Is Not D Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
					Confined Moves About	**Confined** Does Not Move About

IADLS	Needs Help?	
	No 0	D Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Mgmt.		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

OUTCOME: IS THIS A SHORT ASSESSMENT?

____ No, Continue with Section 3 (0) ____ Yes, Service Referrals (1) ____ Yes, No Service Referrals (2)

Screener: _____ Agency: _____

Client Name: *Client SSN:*

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admission: In the past 12 months have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advance directives such as… (Who has it…Where is it…)?

No 0 Yes 1 *Location*

_____ _____ Living Will, _____

_____ _____ Durable Power of Attorney for Health Care, _____

_____ _____ Other, _____

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as … (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset

Enter Codes for 3 Major, Active Diagnoses: _____ **None00** _____ **DX1** _____ **DX2** _____ **DX3**

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Total No. of Medications: _____ **(If 0, skip to Sensory Function)** **Total No. of Tranquilizer/Psychotropic Drugs:** _____

Do you have any problems with medicine(s)…?

No 0 Yes 1

_____ _____ Adverse reactions/allergies

_____ _____ Cost of medication

_____ _____ Getting to the pharmacy

_____ _____ Taking them as instructed/prescribed

_____ _____ Understanding directions/schedule

How do you take your medications?

_____ Without assistance 0

_____ Administered/monitored by lay person 1

_____ Administered/monitored by professional nursing staff 2

Describe help: _____

Name of helper: _____

Diagnoses:
- Alcoholism/Substance Abuse (01)
- Blood-Related Problems (02)
- Cancer (03)
- Cardiovascular Problems
  - Circulation (04)
  - Heart Trouble (05)
  - High Blood Pressure (06)
  - Other Cardiovascular Problems (07)
- Dementia
  - Alzheimer's (08)
  - Non-Alzheimer's (09)
- Developmental Disabilities
  - Mental Retardation (10)
  - Related Conditions
    - Autism (11)
    - Cerebral Palsy (12)
    - Epilepsy (13)
    - Friedreich'a Ataxia (14)
    - Multiple Scierosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
- Digestive/Liver/Gall Bladder (18)
- Endocrine (Gland)Problems
  - Diabetes (19)
  - Other Endocrine Problem (20)
- Eye Disorders (21)
- Immune System Disorders (22)
- Muscular/Skeletal
  - Arthritis/Rheumatoid Arthritis (23)
  - Osteoporosis (24)
  - Other Muscular/Skeletal Problems (25)
- Neurological Problems
  - Brian Trauma/Injury (26)
  - Spinal Cord Injury (27)
  - Stroke (28)
  - Other Neurological Problems (29)
- Psychiatric Problems
  - Anxiety Disorder (30)
  - Bipolar (31)
  - Major Depression (32)
  - Personality Disorder (33)
  - Schizophrenia (34)
  - Other Psychiatric Problems (35)
- Respiratory Problems
  - Black Lung (36)
  - COPD (37)
  - Pneumonia (38)
  - Other Respiratory Problems (39)
- Urinary/Reproductive Problems
  - Renal Failure (40)
  - Other Urinary /Reproductive (41)
- All Other Problems (42)

Client Name:	*Client SSN:*

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment *Record Date of Onset/Type of Impairment*		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers, and legs?

_____ Within normal limits or instability corrected 0
_____ Limited motion 1
_____ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones … Ever had an amputation or lost any limbs … Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
____ None 000	____ None 000	____ None 000
____ Hip Fracture 1	____ Finger(s)/Toe(s) 1	____ Partial 1
____ Other Broken Bone(s) 2	____ Arm(s) 2	____ Total 2
____ Dislocation(s) 3	____ Leg(s) 3	Describe: _____
____ Combination 4	____ Combination 4	
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
____ No/Not Completed 1	____ No/Not Completed 1	____ No/Not Completed 1
____ Yes 2	____ Yes 2	____ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
____ 1 Year or Less 1	____ 1 Year or Less 1	____ 1 Year or Less 1
____ More than 1 Year 2	____ More than 1 Year 2	____ More than 1 Year 2

Nutrition

Height: _____ *(Inches)* Weight: _____ *(lbs.)* Recent Weight Gain/Loss: ____ No 0 ____ Yes 1
Describe: _____

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

Do you take dietary supplements?

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
____	____	Food Allergies
____	____	Inadequate Food/Fluid Intake
____	____	Nausea/Vomiting/Diarrhea
____	____	Problems Eating Certain Foods
____	____	Problems Following Special Diets
____	____	Problems Swallowing
____	____	Taste Problems
____	____	Tooth or Mouth Problems
____		Other: _____

Client Name:	*Client SSN:*

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as…?

No 0	Yes 1		*Frequency*
		Occupational	
		Physical	
		Reality/Remotivation	
		Respiratory	
		Speech	
		Other	

Do you have pressure ulcers?

		Location/Size
	None 0	
	Stage I 1	
	Stage II 2	
	Stage III 3	
	Stage IV 4	

Special Medical Procedures: Do you receive any special nursing care, such as …?

No 0	Yes 1		*Site, Type, Frequency*
		Bowel/Bladder Training	
		Dialysis	
		Dressing/Wound Care	
		Eye care	
		Glucose/Blood Sugar	
		Infections/IV Therapy	
		Oxygen	
		Radiation/Chemotherapy	
		Restraints (Physical/Chemical)	
		ROM Exercise	
		Trach Care/Suctioning	
		Ventilator	
		Other:	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? _____ No 0 _____ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date _____

(Signature/Title)

Client Name: ***Client SSN:***

④ PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: Please tell me your full mane (so that I can make sure our record is correct).
Place: Where are we now (*state, county, town, street/route number, street name/box number*)? *Give the client 1 point for each correct response.*
Time: Would you tell me the date today *(year, season, date, day, month)*?

_____ Oriented 0
_____ Disoriented – Some spheres, some of the time 1
_____ Disoriented – Some spheres, all the time 2
_____ Disoriented – All spheres, some of the time 3
_____ Disoriented – All spheres, all of the time 4
_____ Comatose 5

Spheres affected: _____

Recall/Memory/Judgment

Recall: I am going to say three words. And I want you to repeat them after I am done (House, Bus,Dog). * Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* * Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: * Ask the client to recall the 3 words he was to remember.

Long-Term: When were you born (What is your date of birth)?

Judgment: If you needed help at might, what would you do?

Optional: MMSE Score
(5)
(5)
(3)
(5)
Total:

Note: Score of 14 or below implies cognitive impairment.

No 0	Yes 1	
_____	_____	Short-Term Memory Loss?
_____	_____	Long-Term Memory Loss?
_____	_____	Judgment Problems?

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc…) or become agitated and abusive?

_____ Appropriate 0
_____ Wandering/Passive – Less than weekly 1
_____ Wandering/Passive – Weekly or more 2
_____ Abusive/Aggressive/Disruptive – Less than weekly 3
_____ Abusive/Aggressive/Disruptive – Weekly or more 4
_____ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as …?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
_____	_____	Change in work/employment	_____	_____	Financial problems	_____	_____	Victim of a crime
_____	_____	Death of someone close	_____	_____	Major illness- family/friend	_____	_____	Failing health
_____	_____	Family conflict	_____	_____	Recent move/relocation	_____	_____	Other: _____

Emotional Status

In the past month, how often did you …?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living … or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite … that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1 *Describe*

_____ _____ Solitary Activities, _____

_____ _____ With Friends/Family, _____

_____ _____ With Groups/Clubs, _____

_____ _____ Religious Activities, _____

How often do you talk with your children family or friends either during a visit or over the phone?

Children	**Other Family**	**Friends/ Neighbors**
_____ No Children 0	_____ No Other Family 0	_____ No Friends/Neighbors 0
_____ Daily 1	_____ Daily 1	_____ Daily 1
_____ Weekly 2	_____ Weekly 2	_____ Weekly 2
_____ Monthly 3	_____ Monthly 3	_____ Monthly 3
_____ Less than Monthly 4	_____ Less than Monthly 4	_____ Less than Monthly 4
_____ Never 5	_____ Never 5	_____ Never 5

Are you satisfied with how often you see or hear from your children other family and/or friends?

_____ No 0 _____ Yes 1

Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves emotional/mental health alcohol or substance abuse problems?

_____ No 0 _____ Yes 1

Name of Place	Admit Date	Length of stay/Reason

Do (did) you ever drink alcoholic beverages?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?	**Do (did) you ever use alcohol/other mood-altering substances with …**	**Do (did) you ever use alcohol/other mood-altering substances to help you …**
_____ No 0 _____ Yes 1 **Describe concerns:**	No 0 Yes 1 _____ _____ Prescription drugs? _____ _____ OTC medicine? _____ _____ Other substances? **Describe what and how often:**	No 0 Yes 1 _____ _____ Sleep? _____ _____ Relax? _____ _____ Get more energy? _____ _____ Relieve worries? _____ _____ Relieve physical pain? **Describe what and how often:**

Do (did) you ever smoke or use tobacco products?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

Client Name: ***Client SSN:***

Assessment Summary

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-55.3, to report this to the Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

_____ No $_0$ (Skip to Section on Preferences) _____ Yes $_1$

Where does the caregiver live?

_____ With client 0
_____ Separate residence, close proximity 1
_____ Separate residence, over 1 hour away 2

Is the caregiver's help …

_____ Adequate to meet the client's needs? 0
_____ Not adequate to meet the client's needs? 1

Has providing care to client become a burden for the caregiver?

_____ Not at all 0
_____ Somewhat 1
_____ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preference for receiving needed care: _____

Family/Representative's preference for client's care: _____

Physician's comments (if applicable): _____

Client Name:	*Client SSN:*

Client Case Summary

Unmet Needs

No 0	Yes 1	*(Check All That Apply)*
		Finances
		Home/Physical Environment
		ADLS
		IADLS

No 0	Yes 1	*(Check All That Apply)*
		Assistive Devices/Medical Equipment
		Medical Care/Health
		Nutrition
		Cognitive/Emotional
		Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: **Case assigned to:** **Code #:**

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

Please provide the appropriate answer by either filling in the space or putting the correct code in the box provided.

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ____/____/_____

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐
- 1 = Yes
- 2 = Not currently Medicaid eligible, anticipated within 180 days of nursing home admission **OR** within 45 days of application or when personal care begins.
- 3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing home admission

If no, has Individual formally applied for Medicaid? ☐
0 = No 1 = Yes

Is Individual currently auxiliary grant eligible? ☐
- 0 = No
- 1 = Yes, or has applied for auxiliary grant
- 2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ACR screeners)

MEDICAID AUTHORIZATION

Level of Care ☐
- 1 = Nursing Facility Services
- 2 = PACE/LTCPHP
- 3 = AIDS Waiver Services
- 4 = Elderly & Disabled Waiver - Personal Care
- 5 = Elderly & Disabled Waiver - Adult Day Health Care
- 6 = Elderly & Disabled Waiver - ADHC and Personal Care
- 7 = Elderly & Disabled Waiver - Respite
- 10 = Consumer-Directed Personal Attendant Services
- 11 = ACR Residential Living
- 12 = ACR Regular Assisted Living
- 14 = Individual/Family Developmental Disabilities Waiver

NO MEDICAID SERVICES AUTHORIZED
- 8 = Other Services Recommended
- 9 = Active Treatment for MI/MR Condition
- 0 = No other services recommended

Targeted Case Management for ACR ☐
0 = No 1 = Yes

Assessment Completed ☐
1 = Full Assessment 2 = Short Assessment

ACR provider name: _____
ACR provider number: _____
ACR admit date: _____

SERVICE AVAILABILITY ☐
- 1 = Client on waiting list for service authorized
- 2 = Desired service provider not available
- 3 = Service provider available, care to start immediately

Is this an ACR Reassessment? ☐
0 = No 1 = Yes

Short (Z8577) ☐

Long (Z8578) ☐

LENGTH OF STAY (If approved for Nursing Home) ☐
- 1 = Temporary (less than 3 months)
- 2 = Temporary..(less than 6 months)
- 3 = Continuing (more than 6 months)
- 8 = Not Applicable

LEVEL I/ACR SCREENING IDENTIFICATION

Name of Level I/ACR screener agency and provider number:

1._____

2._____

LEVEL II ASSESSMENT DETERMINATION

Name of Level II Screener and ID number:

1._____

☐
- 0 = Not referred for Level II assessment
- 1 = Referred, Active Treatment needed
- 2 = Referred, Active Treatment not needed
- 3 = Referred, Active Treatment needed but individual chooses nursing home

Did the individual expire after the PAS/ACR Screening decision but before services were received? 1 = Yes 0 = No ☐

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ ____/____/_____
Level I/ACR Screener **Title** **Date**

_____ ____/____/_____
Level I/ACR Screener **Title** **Date**

_____ ____/____/_____
Level I Physician **Date**

GENERAL INFORMATION

- Name of individual being screened
- Social Security Number
- Medicaid number if currently has a Medicaid card. This number should have twelve digits.
- If the individual is not currently eligible for Medicaid, is it anticipated that private funds would be depleted with 180 days after nursing home admission? Formal application for Medicaid is made when the individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care can be made regardless of whether the person has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the person's Medicaid status.
- Assessment for admission to an Adult Care Residence should be completed only for persons eligible for an auxiliary grant or general relief or if the individual has applied. The local Eligibility Department in the person's locality of residence prior to admission to the ACR is the Department which completes the auxiliary grant determination.
- The Department of Social Services with service and eligibility responsibility, may not always be the same agency. Please indicate, if known, the departments for each in the area provided.

MEDICAID AUTHORIZATION: Record only on number in the box in this section to indicate the Pre-Admission Screening authorization.

Nursing Home Pre-Admission Screening

1= **NURSING FACILITY** authorized only if individual meets the nursing facility (NF) criteria and community-based care is not an option.

2= **PACE/LTCPHP** authorize only if individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization within 30 days.

3= **AIDS/HIV SERVICES** authorized only if individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization within 30 days (i.e. case management, private duty nursing, personal/respite care nutritional supplements).

4, 5, 6, 7= **ELDERLY & DISABLED WAIVER SERVICES:** authorize **(PERSONAL CARE, ADULT DAY HEALTH CARE (ADHC) & PERSONAL,** or **RESPITE CARE)** only if individual meets NF or pre-NF criteria and requires a community-based service to prevent institutionalization within 30 days.

10=**CONSUMER-DIRECTED PERSONAL ATTENDANT SERVICES**: authorize only if individual meets NF or pre-NF criteria, is 18 years of age or older, has no cognitive limitations, can self-manage his or her care, does not have an appointed guardian or committee, and requires a community-based service to prevent institutionalization within 30 days.

Adult Care Residence

11=**RESIDENTIAL LIVING** authorize only if individual has dependency in either 1 ADL, IADL, or medication administration.

12=**REGULAR ASSISTED LIVING** authorize only if individual has dependency in either 2 or more ADL's or behavior.

13=**INTENSIVE ASSISTED LIVING** authorize only if individual meets either nursing facility, pre-nursing facility or modified pre-nursing facility criteria and Intensive Assisted Living waiver services will meet the individual's needs.

If 12 or 13 is authorized, enter, if known, the ACR's provider name/number which will admit the individual and the date on which the individual will be admitted to that ACR.

IF 11, 12, OR 13 is authorized, you must indicate whether **targeted ACR case management** (quarterly visits) is being authorized. Resident must require coordination of multiple services and the ACR or other support is not available to assist in coordination/access of these services. Enter a "0" if only the annual reassessment is required.

None

8= **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as Companion services, Meals on Wheels, MR Waiver, Rehab services, etc.).

9= **ACTIVE TREATMENT OF MI/MR CONDITION** applies to those individuals who meet nursing facility level of care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a nursing facility.

0= **NONE** is used when the screening team recommends no services or the individual refuses services.

ASSESSMENT COMPLETED: *If 1-7, 10, 12 or 13 is authorized,* you must complete the full assessment. *If 11 is authorized,* only the short assessment is required.

SERVICE AVAILABILITY: If a Medicaid-funded long-term care service is authorized, indicate whether the service can be started immediately (#3) or whether there is a waiting list (#1) or no available provider (#2).

LENGTH OF STAY: If approval for nursing facility is made, please indicate how long it is felt that these services will be needed by the individual. The physician's signature certifies expected length of stay as well as level of care.

If approved for any other service enter 8.

LEVEL I/ACR SCREENING IDENTIFICATION

Enter the name of the Level I/ACR screening agency or facility (i.e. hospital, local DSS, local Health, Area Agency on Aging, Community Service Board, state MH/MR facility, CIL) and below it, in the 7 boxes provided, that entity's 7 digit screening provider ID#.

In order for Medicaid to make prompt payments to Pre-Admission Screening committees, all of the information in the section must be completed. *Failure to complete any part of this section will delay reimbursement.*

If the screening is a Nursing Home Pre-Admission Screening completed in the locality, there should be two Level I screeners, both the local DSS and local Health departments. Otherwise, there will be only one Level I screener identification entered.

LEVEL II ASSESSMENT DETERMINATION

If the authorization is for nursing facility placement, there must be an entry in this section showing whether a Level II assessment was completed, and if so, whether active treatment was needed. If the Level II assessment for a condition of mental illness or mental retardation was completed, enter the name of the Community Services Board involved and their ID number.

When a screening committee is aware that individual has expired prior to receiving the services authorized by the screening committee, a "1" should be entered.

SCREENING CERTIFICATION: Nursing Home Pre-Admission Screening must be dated and signed by the individual(s) completing the screening; either a registered nurse, social worker or discharge planner and the physician. Adult Care Residence screenings must be signed by a case manager/assessor of the Level I screening agency. The date the screening certification is signed is the earliest date for which Medicaid reimbursed services may be billed. This date for Nursing Home Pre-Admission Screening is the date signed by the physician.

SCREENING TEAM PLAN OF CARE FOR MEDICAID-FUNDED LONG TERM CARE

Individual Being Screened: _____ Medicaid ID#: _____

I SCREENING TEAM DETERMINATION: Refer to Appendix B, NHPAS manual

A. **Individual Meets Nursing Facility Criteria** (Functional Dependency Level and Medical/Nursing Need Present):
□ Yes *(must be checked to authorize Nursing Facility Placement)* □ No

B. **Individual is At Imminent Risk** (within 30 days of application**) of Nursing Facility Placement if Community-Based Care Is Not Offered:** □ Yes □ No

□ Application for the individual to a nursing facility has been made and accepted. Date application was made: _____
Facility: _____ Contact: _____

□ Deterioration in individual's health care condition or changes in available support prevents former care arrangements from meeting needs.
Describe: _____

□ Evidence is available that demonstrates individual's medical and nursing needs are not being met (e.g. Recent doctor's documentation of instability, findings from medical/social service agencies).
Describe: _____

Complete Section II ONLY if Nursing Facility Criteria and Risk of Waiver Services Placement are Met

I CHOICE AND PAYMENT RESPONSIBILITY

Medicaid will pay for someone to come into your home to care for you as long as in-home services will safely meet your needs and will not be more expensive than nursing facility care. You may choose to receive in-home services as long as there is an available provider in your area and, either you have some additional support from family, friends, or you are able to manage without additional help when the in-home services are not being provided.

To stay at home, help in the following areas are needed (check as many as needed): □ ADLs □ Housekeeping □ Meal Preparation □ Shopping □ Laundry □ Supervision *(Attach DMAS-100)* □ PERS *(Attach DMAS-100A)* □ Transportation □ Skilled Needs

Please identify any people or agencies that are able to provide you with assistance, either on a regular basis or as needed:

People/Agencies	What Areas of Help Will They Provide	# Days & Hours/Week

I RECIPIENT CHOICE TO RECEIVE THE FOLLOWING COMMUNITY-BASED CARE INSTEAD OF NURSING HOME CARE

□ Consumer-Directed Personal Attendant Services (CD-PAS) requested _____ days/week

□ Elderly & Disabled Waiver (E&D)

□ Personal Care services requested _____ days/week.

□ Adult Day Health Care services requested _____ days/week from _____ a.m. to _____ p.m.

□ Both *(ADHC & Personal Care services)* □ Transportation is needed for ADHC services

_____ *(Provider Agency)* has been chosen and contacted and is able to provide the services requested. I understand that the provider will develop a Plan of Care with my assistance based on my needs and my available support. Provider staff is responsible to provide continuous, reliable care, but there may be an occasional lapse in service for which I will need to provide back-up support. (Under Consumer-Directed Personal Attendant Services, I understand the responsibilities associated with employing my own personal attendants). I understand that, based on my income, I may have a co-pay of $_____/month, regardless of the amount of community-based care received.

Client Signature	Date	Screener's Signature	Date

IV NURSING FACILITY CHOICE AND PAYMENT RESPONSIBILITY

Community-based care alternatives were explained completely but were not an option for me because _____

☐ I choose to receive nursing facility care and requesting admission to _____(facility). I understand that I may have to pay $ _____/ mo. in order to receive nursing facility care. Community-based/in-home care has been explained completely and I understand the options for services that are available? ☐ Yes ☐ No

Client's Signature	Date	Screener's Signature	Date

DMAS-97
revised 12/02

Section I: Screening Determination

Item A must be checked if authorizing Nursing Facility Placement

Item A or at least one of the conditions in B must be completed if authorizing Community-Based Care Services

Section II: Community Care Choice and Payment Responsibility

Section II must be completed in its entirety if Community Based Care criteria is met and client chooses Community Based Care Services. Please remember to obtain client's signature that assures the client was given a choice of providers and was advised of their possible patient pay responsibility.

The screener must check services that the recipient will need in order to remain at home.

The screening committee must explain to the client that the screening committee does not authorize the amount of services or times of day or days of week on which services will be provided. The provider agency will make that decision with the client based on their needs and wishes identified during the screening.

Section III: Nursing Facility Choice and Payment Responsibility

Section III must be completed in its entirety if Nursing Facility Criteria is met and the recipient chooses Nursing Facility Placement. Please remember to obtain client's signature that assures the client was offered Community-Based Care alternatives and chooses Nursing Facility Placement

CONSUMER-DIRECTED SERVICES PLAN OF CARE

RECIPIENT NAME:_____ **MEDICAID ID #**_____

PROVIDER AGENCY:_____ **AGENCY ID #**_____

FOR EACH TASK TO BE DONE, ENTER TIME FOR EACH CATEGORY AND ADD FOR TOTAL TIME

Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
ADL'S DATE:	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Bathing							
Dressing							
Toileting							
Transfer							
Grooming							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
ADL Time:							
IADLS							
Meal Preparation							
Housekeeping							
Shopping							
Money Management							
Transportation							
Laundry							
Work/School/ Social							
IADLS Time:							
Total Daily Time:							

Composite ADL Score = (The sum of the ADL ratings that describe this recipient.)

BATHING SCORE

Bathes without help or with MH only	0
Bathes with HH or with HH & MH	1
Is Bathed	2

TRANSFERRING SCORE

Transfers without help or with MH only	0
Transfers w/ HH or w/HH & MH	1
Is Transferred or does not transfer	2

DRESSING SCORE

Dress without help or with MH only	0
Dresses with HH or with HH & MH	1
Is dressed or does not dress	2

EATING SCORE

Eats without help or with MH only	0
Eats with HH or HH & MH	1
Is fed: Spoon/tube/etc.	2

AMBULATION SCORE

Walks/Wheels without help/ w/MH only	0
Walks/Wheels w/ HH or HH & MH	1
Totally Dependent for mobility	2

CONTINENCY SCORE

Continent / incontinent < weekly self care of internal / external devices	0
Incontinent weekly or > Not self care	2

LEVEL OF CARE: (LOC)	☐ **A** (Score 4 - 6) Maximum Hours of 25/Week	☐ **B** (Score 7 - 12) Maximum Hours 30/Week	☐ **C** (Score 9 +) Maximum Hours 35/Week

The Amount of Time Needed to Complete All Tasks must Not Exceed The Maximum For the Specified LOC.

Reason Plan of Care Submitted: ☐ New Admission ☐ > In Hours ☐ < In Hours ☐ Transfer

Effective Date of Plan of Care: _____ Total Weekly Hours: _____

Recipient's Emergency / Back Up Plan: _____

_____

Service Coordinator Signature: _____ Recipient's Signature: _____

WVMI

6802 Paragon Place

CARE
Suite 410
Richmond, Virginia 23230
Ph: 1-804-648-3159
Toll Free: 1-800-299-9864

___ New Request

REQUEST FOR SERVICES FORM

Fax: 1-804-648-6992
Toll Free: 1-866-510-7074

COMMUNITY BASED

___ Pend Response
___ Change to Approval
(must incl. PA#)

Recipient Medicaid #_____Name:(last)_____(first)_____
Recipient Phone # (Attendant Care and Consumer Directed Respite Only) (_____) ____-____ SS# ___-___-____ DOB: ____/____/____ Waiver: _____
Provider # _____ Provider Name: _____
Contact Person: _____ Phone # _____ Fax: _____

Request Information:				WVMI Use Only:				WVMI Use:
Service	Type	Hours	Effective Date	Hours	Effective Date	Status	PA #	Date / Reviewer
_____	_____	_____	____/_____/_____	_____	____/_____/_____	_____	_____	_____ / _____
_____	_____	_____	____/_____/_____	_____	____/_____/_____	_____	_____	_____ / _____
_____	_____	_____	____/_____/_____	_____	____/_____/_____	_____	_____	____ _____ / _____
_____	_____	_____	____/_____/_____	_____	____/_____/_____	_____	_____	_____ / _____
_____	_____	_____	____/_____/_____	_____	____/_____/_____	_____	_____	_____ / _____

This preauthorization request cannot be processed due to missing, incomplete or illegible information.
Please attach the requested information to WVMI within 30 days.

Medicaid ID #	Provider #	Provider Name	
Respite Provider #	Last Date of Service	# of Respite Hours Used	DMAS 115
Type	Service	Effective Date	DMAS 101A
DMAS 101 B	DMAS 100	DMAS 100A	DMAS 97 A

WVMI TRACKING NUMBER:

Provider Comments:	WVMI Comments:

DMAS 98 03/10/03

CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____, AM SIGNING THIS FORM FOR

(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

_____

(FULL PRINTED NAME OF CLIENT)

_____

(CLIENT'S ADDRESS) (CLIENT'S BIRTH DATE) (CLIENT'S SSN – OPTIONAL)

My relationship to the client is: □ Self □ Parent □ Power of Attorney □ Guardian
□ Other Legally Authorized Representative

I want the following confidential information about the client (except drug or alcohol abuse diagnoses or treatment information) to be exchanged:

Yes No	Yes No	Yes No
□ □ Assessment Information	□ □ Medical Diagnosis	□ □ Educational Records
□ □ Financial Information	□ □ Mental Health Diagnosis	□ □ Psychiatric Records
□ □ Benefits/Services Needed Planned, and/or Received	□ □ Medical Records	□ □ Criminal Justice Records
	□ □ Psychological Records	□ □ Employment Records

Other Information (write in):

I want:_____

_____

(*NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)*

And the following other agencies to be able to exchange this information:

Are More Agencies Listed on the Back? □ Yes □ No

I want this information to be exchanged ONLY for the following purpose(s);

□ Service Coordination and Treatment Planning □ Eligibility Determination

Other:_____

I want information to be shared: (check all that apply)

□ Written Information □ In Meetings or By Phone □ Computerized Data

I want to share additional information received after this consent is signed: □ YES □ NO

This consent is good until:_____

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.

I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information.

IF I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

*Signature(s):*_____ *Date:*_____

(CONSENTING PERSON OR PERSONS)

*Person Explaining Form:*_____

(Name) (Title) (Phone Number)

*Witness (If Required):*_____

(Signature) (Address) (Phone Number)

DMAS 20
6/94

CONSENT TO EXCHANGE INFORMATION FORM

FULL PRINTED NAME OF CLIENT:_____

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

- ☐ Revoked in entirety
- ☐ Partially revoked as follows:

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REQUEST RECEIVED:_____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

_____

(*AGENCY REPRESENTATIVE'S FULL NAME AND TITLE)*

Consumer-Directed Personal Attendant Services Recipient Assessment Report

☐ Initial (Comprehensive) ☐ Routine (30-60 Days) ☐ Six-Month Re-assessment / Desk Review

☐ Post Nursing Facility Discharge Assessment (Fill out a DMAS-97) Date D/C from NF: _____

☐ Post Hospitalization Discharge Assessment (Full Assessment) Date D/C from Hospital: _____

Recipient's Name: _____ Date of Birth: _____

Medicaid ID #: _____ Start of Care: _____

Recipient's Current Address: _____ Agency Name: _____

_____ Provider ID #: _____

Recipient's Phone: ( ) _____

FUNCTIONAL STATUS (Shaded areas denote independence or mechanical dependence)

ADLS	Needs No Help	MH Only	Human Help		MH & Human Help		Performed By Others	Is Not Performed
			Supervise	Phys. Asst.	Supervise	Phys. Asst.		
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

CONTINENCE	Continent	Incontinent < Weekly	Incontinent Self Care	Incontinent Weekly or >	External Device Not Self Care	Indwelling Cath Not Self Care	Ostomy Not Self Care
Bowel							
Bladder							

MOBILITY

Needs No Help	MH Only	Human Help		MH & Human Help		Confined Moves About	Confined Does Not Move About
		Supervise	Phys. Asst.	Supervise	Phys. Asst.		

ORIENTATION:

Oriented	Disoriented-Some Spheres/Sometime	Disoriented-Some Spheres/All Times	Disoriented-All Spheres/Sometimes	Disoriented-All Spheres/All Time	Semi-Comatose/ Comatose

Spheres Affected: Source of Info:

BEHAVIOR

Appropriate	Wandering/Passive < Than Weekly	Wandering/Passive Weekly or >	Abusive/Aggressive/ Disruptive< Weekly	Abusive/Aggressive/ Disruptive > Weekly	Semi-Comatose/ Comatose

Describe Inappropriate Behavior:

Source of Info:

JOINT MOTION: **MED. ADMINISTRATION:**

MEDICAL/NURSING INFORMATION

Diagnoses _____

_____

Current Health Status/Condition: _____

_____

_____

Current Medical Nursing Needs: _____

_____

Therapies/Special Medical Procedures: _____

_____

Hospitalizations: Date(s): _____ Reason(s): _____

DMAS-99B (09/02)

Consumer-Directed Personal Attendant Services Recipient Assessment Report

SUPPORT SYSTEM

Hours Attendant(s) Provides Care to Recipient: Total Weekly Hours:_____ Days per Week:_____
Other Medicaid/Non-Medicaid Funded Services Received:_____
_____
Family/Other Support:_____
_____
_____
Who is the recipient's back-up support?_____
_____

SERVICE FACILITATOR SUPERVISION

Dates of Service Facilitator routine visits for the last 6 months:_____
Does the care plan reflect the needs of the Recipient? ☐ Yes ☐ No
If No to either, please describe follow-up:_____
_____
_____

CONSISTENCY AND CONTINUITY

Number of Days of No Service In the Last 6 Months: (Do Not include Hospitalizations)_____
Number of Attendants Assigned to Case in the Last 6 Months: Regular Attendants : _____ Sub-Attendants:_____
Has the recipient or caregiver had any problems with the care provided in the last six months? ☐ Yes ☐ No If Yes, please describe problem(s) and the follow-up taken:_____
_____

Date of most recent DMAS 122: _____ Patient Pay Amount:_____

Service Facilitator's Signature:_____ Date: _____

Attendant Present? ☐ Yes ☐ No Name of Attendant: _____ Regular Attendant ☐ / Sub Attendant ☐

SERVICE FACILITATOR'S NOTES: (They may utilize space below for documentation of pertinent issues that may occur between home visits)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SERVICE FACILITATOR'S SIGNATURE: _____ Date:_____

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219

INSTRUCTIONS FOR COMPLETION OF THE DMAS-99B

The consumer-directed service facilitator (CDSF) must use this form. The instruction for filling out the DMAS-99B may vary with the type of visit that is conducted. Check the appropriate box at the top of page one. The Initial and the Six-Month Re-assessment visit requires the entire DMAS-99B to be filled out completely. The Routine supervisory visit may allow an update of the previous Routine supervisory visit's information. The Post Nursing Facility Discharge Assessment, if the recipient is admitted into waiver services within 12 months of the nursing facility discharge date the service facilitator must fill out a DMAS-97B along with the DMAS-99B. The Post Hospitalization Discharge Assessment, if waiver services have been provided within the last 12-months, the DMAS-99B needs to be filled out completely by the CDSF.

Detailed instructions for filling out the DMAS-99B is provided below. If you have further questions, please call the Waiver Services Unit for assistance at (804) 786-1465.

THE INITIAL AND SIX-MONTH REASSESSMENT VISIT

It must include: the recipient's name, address, date of birth, phone number, Medicaid ID number, the start of care date, and the provider agency's name and provider number.

FUNCTIONAL STATUS: Must be completed in detail on the initial visit and during the six-month reassessment visit. The recipient's dependence or independence in an ADL should be noted by placing a check mark in the appropriate box under each category. Apply the definitions provided in the Virginia Uniform Assessment Instrument (UAI) user's manual when assessing the recipient and completing this section. If there is any doubt in the recipient's ability to perform a task, the CDSF should ask the recipient to demonstrate the completion of that task. Shaded areas indicate the recipient is independent in that function. "Independent" means that the recipient does not need an aide to assist with any part of the task. Under JOINT MOTION, it should be noted which joints are limited (if applicable). Under MED. ADMINISTRATION, note who administers the recipient's medications.

MEDICAL/NURSING INFORMATION: All of these blanks must be completed on the initial and six-month assessments. DIAGNOSES- All diagnoses contributing to the health needs of the recipient should be noted on this visit. Remember that the recipient may have developed another medical complication requiring the documentation of another diagnosis. CURRENT HEALTH STATUS/CONDITION- Note information such as weight loss or gain (if pertinent), medication changes, MD visits, including for what reason, and whether the recipient's condition has improved, declined, or remained stable. The CDSF must assess this issue by asking pointed questions, (e.g., have you seen the doctor since I was here last time? Did the doctor change your medication? Have you been having any dizzy spells? Have you been able to eat all of your meals without vomiting afterward? Are you still having headaches? Are you checking your sugar four times a day?). CURRENT MEDICAL NURSING NEEDS- Include any information that should be monitored by the CDSF or the doctor, such as, blood sugar levels, wounds, weight loss, malnutrition, dehydration, respiratory distress, immobility issues, circulatory problems, blood-work for medication adjustments. This is not asking for a summary of the recipient's ADL functioning. THERAPIES / SPECIAL MEDICAL PROCEDURES- This must be addressed on the initial assessment and six-month reassessment. Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health skilled services, note frequency of visits, the agency providing services, and the reason(s) & disciplines for visits. HOSPITALIZATIONS- Include the dates of admission and discharge, and the reason(s) for the admission.

SUPPORT SYSTEM: Must be completed in detail on these visits. Any changes in the hours on the Plan of Care or the support system should be noted. TOTAL WEEKLY HOURS AND DAYS PER WEEK- This should reflect the hours and days on the current plan of care. OTHER MEDICAID/NON FUNDED SERVICES- This must be filled out.

SERVICE COORDINATOR SUPERVISION: Dates of Facilitator's supervisory visits for the last six months must be completed on the six-month reassessment. Document if the attendant is following the recipient plan of care, or if not, documenting the reason for not following the plan of care. If the Facilitator's plan of care is not being followed by the attendant due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer "NO", and explain, including how the plan of care will be changed to meet the recipient's needs if it needs to be.

CONSISTENCY AND CONTINUITY: The number of no service days within the last six months must be indicated on the six-month reassessment. Do not include days the recipient/caregiver requested to be without service or days the recipient was hospitalized. Note how many attendants have been assigned over the past six months as well as how many substitute attendants were utilized. If the recipient or caregiver(s) has been dissatisfied with the attendant, service facilitator, facilitator agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Record the date and patient pay amount (if applicable) from the most recent DMAS 122.

The Facilitator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the Facilitator's signature when conducting utilization review. The DMAS-99B must be filed in the recipient's record within five days of the date of the last visit. If an attendant was present in the home at the time of the visit, note the attendant's full name and whether the attendant is regularly assigned or is being utilized as a substitute attendant on this day.

SERVICE COORDINATOR NOTES: Utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

ROUTINE FACILITATOR SUPERVISORY VISITS:

The recipient's address, date of birth, start of care date, and phone number may be omitted on the routine reassessment, if desired.

FUNCTIONAL STATUS: If it is determined that there has been no change in the functional status, a line may be drawn through all of the Functional Status boxes and "No Change" written.

MEDICAL/NURSING INFORMATION: This area must be completed on every ROUTINE visit. If the diagnoses have not changed, NO CHANGE may be written on this line during the ROUTINE visit. New diagnoses may be added as indicated on the ROUTINE reassessment note. Current health status/condition must be addressed monthly and note information such as weight loss or gain (if pertinent) medication changes, MD visits-including for what reason, and whether the recipient's condition has improved, declined, or remained stable since the last reassessment. Current Medical Nursing Needs, must be updated monthly on the ROUTINE reassessment note if indicated. Medical Nursing Needs must be present if the recipient meets the nursing facility criteria. Therapies/Special Medical Procedures: Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health, note frequency of visits, agency providing services, and reason for visits. Hospitalizations: Include the dates of admission and discharge, and the reason for the admission.

SUPPORT SYSTEM: Any changes regarding hours on the plan of care or the support system should be noted. Total Weekly Hours and Days per Week should reflect the hours and days on the current plan of care. Other Medicaid/Non Funded Services should be filled out.

SERVICE COORDINATOR SUPERVISION: document if the attendant is not following the plan of care and the reason(s) why. If the Facilitator's plan of care is not being followed by the attendant due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer "NO", and explain, including how the plan of care will be changed to meet the recipient's needs if it needs to be.

CONTINUITY & CONSISTENCY: If the recipient or caregiver(s) has been dissatisfied with the attendant, service facilitator, facilitator agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Note the date and patient pay amount (if applicable) from the most recent DMAS 122**.**

The facilitator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the facilitator's signature when conducting utilization review. The DMAS-99B must be filed in the recipient's record within five days of the date of the last visit. If an attendant was present in the home at the time of the visit, note the attendant's full name and whether the attendant is regularly assigned or is being utilized as a substitute attendant on this day.

SERVICE COORDINATOR NOTES: Utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

MI/MR LEVEL I SUPPLEMENT FOR ELDERLY & DISABLED WAIVER APPLICANTS

A. This section is to be completed by the Nursing Home Pre-admission Screening Committee for individuals with MI and/or MR diagnoses seeking services under the Elderly and Disabled waiver.

Name: _____ Date of Birth: _____ Date NHPAS Request Received _____

Social Security No. _____ Medicaid No. _____ Responsible CSB _____

1. DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?
   ❒ Yes ❒ No (Check "Yes" only if both a and b below are answered "Yes".)
   a. Does the individual meet the program criteria for the Elderly and Disabled Waiver AND is the individual at imminent risk? ❒ Yes ❒ No
   b. Can a safe and appropriate plan of care be developed to meet all medical/nursing/custodial care needs? ❒ Yes ❒ No

   (If "Yes", this form must be completed. If "No", do not complete Level I screening and do not refer for assessment of active tx needs. Individuals who do not meet the above criteria cannot be approved for Medicaid funded waiver services.)

2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)? ❒ Yes ❒ No
   (Check "Yes" only if answers a, b, and c below is "Yes". If "No", do not refer for assessment of active tx needs for MI Diagnosis.)
   a. Is this major mental disorder diagnosable under DSM-IV (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)? ❒ Yes ❒ No
   b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? ❒ Yes ❒ No
   c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? ❒ Yes ❒ No

3. DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF MENTAL RETARDATION (MR), WHICH WAS MANIFESTED BEFORE AGE 18? ❒ Yes ❒ No

4. DOES THE INDIVIDUAL HAVE A RELATED CONDITION? ❒ Yes ❒ No
   (Check "Yes" only if each item below is Checked "Yes". If "No", do not refer for Level II PAS for related condition.)
   a. Is the condition attributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina befida), other than MI, found to be closely related to MR because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR persons and requires treatment of services similar to those for these persons? ❒ Yes ❒ No
   b. Has the condition manifested before age 22? ❒ Yes ❒ No
   c. Is the condition likely to continue indefinitely? ❒ Yes ❒ No
   d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living? ❒ Yes (circle applicable areas) ❒ No

5. RECOMMENDATION (Either "a" or "b" must be checked.)
   a. ❒ Refer for Level II assessment for **:
      ❒ MI (# 2 above is checked "Yes")
      ❒ MR or Related Condition (# 3 or # 4 is checked "Yes")
      ❒ Dual diagnosis (MI and MR/Related Condition categories are checked)

** NOTE: If 5a is checked, the individual may NOT be authorized for Medicaid-funded waiver until the CSB has completed the DMAS-101B.
   b. ❒ No referral for active treatment needs assessment required because individual:
      ❒ Does not meet the applicable criteria for serious MI or MR or related condition
      ❒ Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of MR
      ❒ Has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of a serious MI
      ❒ Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stern level, or other conditions which result in a level of impairment so sever that the individual could not be expected to benefit from specialized services.)
      ❒ Is terminally ill (note: a physician must have documented that individual's life expectancy is six (6) months or less)

Signature & Title: _____ Screening Committee: _____

Date: _____ Telephone #: _____ Street Address: _____

INSTRUCTIONS FOR COMPLETION OF THE DMAS 101B
PROCESS FOR AUTHORIZING CBC SERVICES FOR PERSONS WITH MI/MR CONDITION

The pre-admission screening team must have this form completed when the person being screened has a condition of mental illness or mental retardation and the person is requesting community-based care services (Personal Care, Adult Day Health Care, Respite Care). Once the screening team determines that the person meets the criteria for CBC services (meets NF or Pre-NF criteria and is at risk of NF placement unless CBC services are offered) the screening team must complete the top portion of the DMAS 101, attach a copy of the UAI and send the two forms to the CSB for an evaluation of the person's need for MH/MR services. This must be done before the screening team completes the DMAS 96 to authorize services.

Any time the screening team has the CSB complete the MH/MR Service Needs Summary Form, *a copy must be attached* to the packet submitted to DMAS for reimbursement and a copy to the Elderly and Disabled waiver provider if services through this waiver are authorized.

Assessment of Active Treatment Needs for Individuals with MI, MR or RC who Request services under the E&D Waiver

Attached is an assessment completed by _____ Preadmission Screening Team to determine the need and appropriateness of community-based services under the Elderly and Disabled Waiver (personal care, adult day health care, and /or respite care) for_____.
(Person Applying for Service)

As part of our assessment process, we have determined that the individual has:
____ *A condition of mental illness which requires assessment for services needed*
____ *A condition of mental retardation which requires assessment for services needed*

Please complete the information below and return it to _____ within 72 hours of
(Name of Screener Making Referra l Phone #)
the date referred _____ so that the assessment and authorization process can be completed.

TO BE COMPLETED BY THE COMMUNITY SERVICES BOARD (Attach additional information as needed.)

The _____ Community Services Board assessed the needs of the individual
(Name of CSB)
referenced above on _____.
(Date assessment completed)

1. ¨ The individual does have a condition of mental illness or mental retardation and has the following active treatment needs:
_____
_____
_____
_____
_____

a. Active Treatment needs will be met by:
_____
_____
_____

b. If active treatment needs are met by a third party, please attach verification from the third party that all active treatment needs are being met. Also, if active treatment needs are being met by the school system, please explain how active treatment needs will be met during summer vacation:
_____
_____
_____

2. ¨ The individual does have a condition of mental illness or mental retardation, but could not benefit from services. Please explain. ***(Note if this block is checked, but there is no explanation, services under the E&D Waiver cannot be authorized.)***
_____
_____
_____

3. ¨ The individual does not have a condition of mental illness or mental retardation and therefore does not need treatment or services from the CSB.

Name of individual who completed assessment: (Please print name)_____

Signature of individual who completed assessment:_____

Phone Number: _____Date Signed:_____

DMAS 101B revised 9/02

INSTRUCTIONS FOR COMPLETION OF THE DMAS 101B
PROCESS FOR AUTHORIZING CBC SERVICES FOR PERSONS WITH MI/MR CONDITION

The pre-admission screening team must have this form completed when the person being screened has a condition of mental illness or mental retardation and the person is requesting community-based care services (Personal Care, Adult Day Health Care, Respite Care). Once the screening team determines that the person meets the criteria for CBC services (meets NF or Pre-NF criteria and is at risk of NF placement unless CBC services are offered) the screening team must complete the top portion of the DMAS 101, attach a copy of the UAI and send the two forms to the CSB for an evaluation of the person's need for MH/MR services. This must be done before the screening team completes the DMAS 96 to authorize services.

Any time the screening team has the CSB complete the MH/MR Service Needs Summary Form, *a copy must be attached* to the packet submitted to DMAS for reimbursement and a copy to the Elderly and Disabled waiver provider if services through this waiver are authorized.

Assessment of Active Treatment Needs for Individuals with MI, MR or RC who Request services under the Elderly and Disabled and C-DPAS Waiver

Attached is an assessment completed by _____ Preadmission Screening Team to determine the need and appropriateness of community-based services under the Elderly and Disabled Waiver (personal care, adult day health care, and /or respite care) for_____.
(Person Applying for Service)

As part of our assessment process, we have determined that the individual has:
____ *A condition of mental illness which requires assessment for services needed*
____ *A condition of mental retardation which requires assessment for services needed*

Please complete the information below and return it to _____ within 72 hours of
(Name of Screener Making Referra l Phone #)
the date referred _____ so that the assessment and authorization process can be completed.

TO BE COMPLETED BY THE COMMUNITY SERVICES BOARD (Attach additional information as needed.)

The _____ Community Services Board assessed the needs of the individual
(Name of CSB)
referenced above on _____.
(Date assessment completed)

1. ¨ The individual does have a condition of mental illness or mental retardation and has the following active treatment needs:
_____
_____
_____
_____
_____

a. Active Treatment needs will be met by:
_____
_____
_____

b. If active treatment needs are met by a third party, please attach verification from the third party that all active treatment needs are being met. Also, if active treatment needs are being met by the school system, please explain how active treatment needs will be met during summer vacation:
_____
_____
_____

2. ¨ The individual does have a condition of mental illness or mental retardation, but could not benefit from services. Please explain. ***(Note if this block is checked, but there is no explanation, services under the E&D Waiver cannot be authorized.)***
_____
_____
_____

3. ¨ The individual does not have a condition of mental illness or mental retardation and therefore does not need treatment or services from the CSB.

Name of individual who completed assessment: (Please print name) _____

Signature of individual who completed assessment: _____

Phone Number: _____ Date Signed: _____

DMAS 101B revised 9/02

OUTLINE & CHECK LIST FOR
CONSUMER-DIRECTED RECIPIENT TRAINING

(Check (√) the box after completing each part of the training.)

I. THE SERVICE COORDINATOR, THE PERSONAL ATTENDANT, AND THE RECIPIENT

☐ A. Introduction to the Program

☐ 1. Structure of organization

☐ 2. Overall programs of the agency

☐ 3. Agency policies and procedures (e.g., payroll, record keeping, confidentiality, ethics)

☐ B. Consumer Directed – Personal Attendant Services

☐ 1. Definition of services

☐ 2. The approach to provision of services

a. Personnel involved (e.g., service coordinator, fiscal agent) (Have recipient read and sign service agreements for service coordinator and fiscal agent if they haven't been

☐ signed yet)

☐ 3. Role of the personal attendant in the provision of services

II. The Recipient of Personal Attendant Services

☐ A. Recipient needs inventory

☐ 1. Assessing needs as a recipient (e.g., habits, personal care)

☐ B. How to Select and Hire Personal Attendants

☐ 1. Creating a personal attendant job description (discuss sample)

☐ 2. Advertising for personal attendants (discuss sample)

☐ 3. Assessing a personal attendant's application

☐ 4. Required qualifications of personal attendants

☐ 5. Screening applicants and scheduling interviews

☐ C. Hiring Personal Attendants

☐ 1. Obtaining personal attendant work record

☐ 2. Interviewing a prospective client (questions to think about)

☐ 3 Consumer selection of Personal Attendant

☐ 4 Conducting a criminal history/references check

☐ 5. Record Keeping

III. Personal Attendants

☐ A. Philosophy of personal attendants

☐ 1. Policies for personal attendants

- ☐ B. Payroll requirements for each personal attendant
- ☐ 1 Employment eligibility verification (I-9)
- ☐ 2. W-4 Form completion
- ☐ C. Competency determination of personal attendants
- ☐ 1 Competency certificate

IV. Contractual Agreements

- ☐ A. Agreement between consumer and personal attendant
- ☐ 1. Sample personal attendant agreement
- ☐ 2. Sample contract

V. Training Personal Attendants

- ☐ A. The provision of services by the personal attendant
- ☐ 1. Included services/excluded services
- ☐ 2. Sample personal attendant duties check-list
- ☐ 3. Personal attendant job evaluations
- ☐ B. Communicating with your personal attendant
- ☐ 1. Creating a good work environment
- ☐ 2. Establishing rapport
- ☐ 3. Resolving conflict
- ☐ C. Important Considerations
- ☐ 1. Firing the personal attendant
- ☐ 2. Emergency back-up personal attendant
- ☐ 3. Substitution of attendants
- ☐ 4. Accidents on the job
- ☐ 5. Unexpected death and the personal attendant

VI. Completing Personal Attendant Time Sheets

- ☐ A. Certification of services rendered (Explanation of time sheet)
- ☐ B. Understanding of relinquishment of patient co-pay amount
- ☐ C. Discontinued employment

This is to be filled out by the CD Service Facilitator during the Training and signatures obtained after the training.
This must be maintained in the recipient's file.

CD-PAS Recipient/Caregiver's Signature _____ Date _____

CD Service Facilitator's Signature _____ Date _____

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